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Reader's Guide

The general secretary of the Canadian Nurses' Association, **Gertrude M. Hall,** needs no introduction to the nurses of Canada. With her keen perceptive ability and fluent vocabulary she brings us an intimate picture of the problems and shortages our colleagues in Britain are facing this winter. Read her interesting and pathetic account of her visit over there during the early autumn. Contrast our bountiful lot with theirs and then let us all see what we can do to bring some joy to our fellow-nurses.

A few years ago, primary tuberculosis was regarded as a condition of adolescence. The middle teen-age was the common period at which it occurred. **Dr. G. F. Kincade** informs us that the age group has shifted in recent years to the young adult. He attributes this change to the growing number of young people who have negative skin tests well on to adulthood. Dr. Kincade is director of the Vancouver Unit of the British Columbia Division of Tuberculosis Control.

Urgent appeals for more nurses have been coming from our tuberculosis sanatoria for many years. **Mabel Sharpe** feels that part of the answer lies in equipping our student nurses with a fuller knowledge of the disease through undergraduate affiliation and thus eliminating the bogey of fear which seems to be such a dominant factor. Miss Sharpe is superintendent of nurses at the Essex County Sanatorium, Windsor, Ont.

Many persons have advocated a broader use of B.C.G. as a means of providing added protection for student nurses. **Laura I. M. Coleman,** who describes this prophylactic measure for us, is a senior medical student at McGill University.

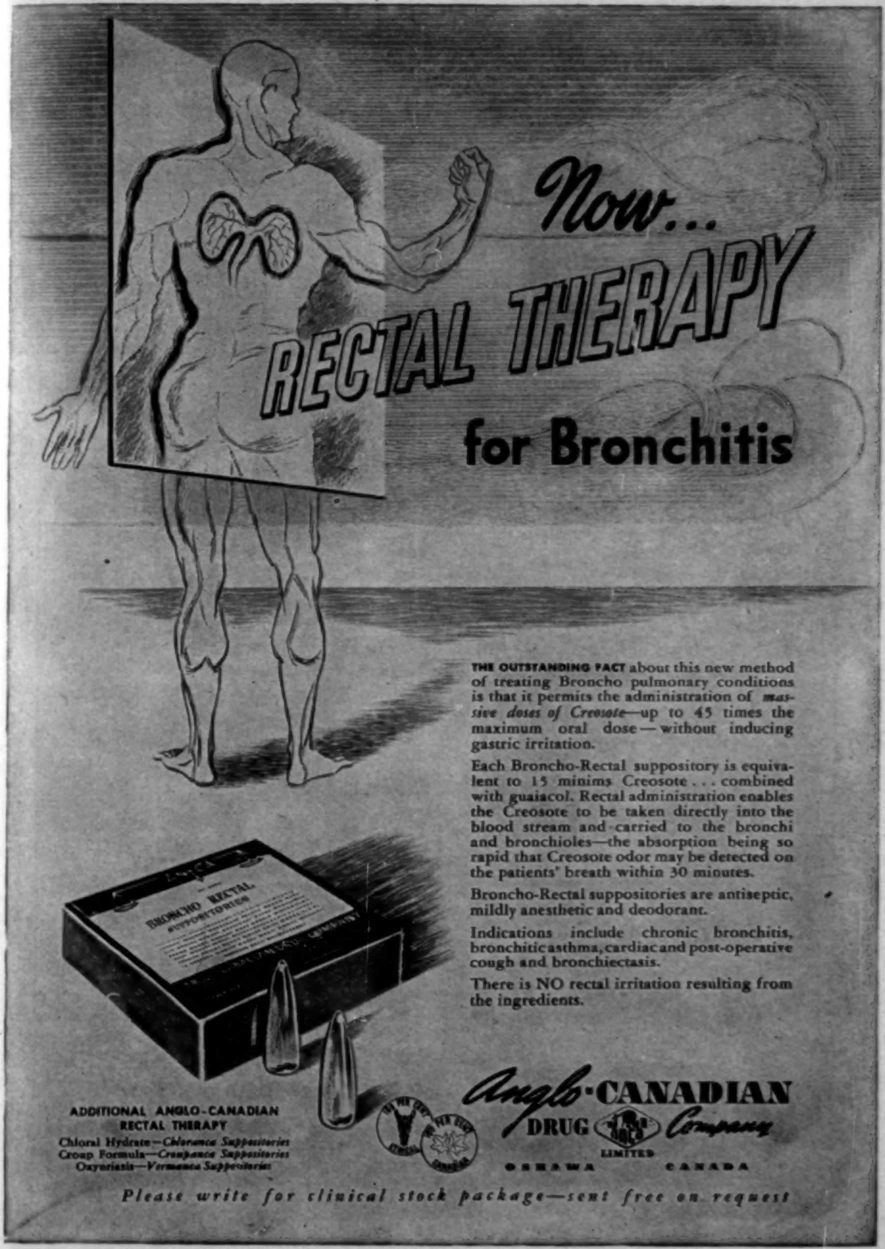
The rapid development of neurosurgery in modern medical practice has placed many new and varied responsibilities on the nursing staffs. **Elizabeth K. McCann's** presentation of the techniques involved in a prefrontal lobotomy, and the consequent nursing care, will add greatly to the nurse's knowledge and skill when she is confronted with patients who have had this delicate operation.

How best can the supervisor assist with the growth and developing maturity of the student? **Helen M. Mann** gives us some interesting answers to this question on the Hospital and School of Nursing Page. Miss Mann is on the faculty of the School of Social Service at the University of Manitoba.

For a long time there has been a demand from public health nurses for an authoritative list of agencies, companies, etc., to whom they might write for educational materials for use in their work. Here it is at last! The energetic secretary of the Public Health Section, C.N.A., **Sheila MacKay,** has spent many months and has had voluminous correspondence in the course of compiling this list. We feel it will be of especial value to the hundreds of new public health nurses who are employed in this rapidly expanding field. Don't lose your copy for there will not be any reprints made of this list.

Roger Ouimet, who has written an illuminating account of the steps taken in the development of a provincial registered nurses' act, is the legal adviser of the R.N.A.P.Q. Brush up on your French by reading this interesting explanation on the French Page 'Aux Infirmières Canadiennes-Françaises."

In **Notes from National Office** is presented the first report of the meeting of the Executive Committee of the International Council of Nurses held in London in September. The dates have been set for the first post-war congress of the I.C.N. in Atlantic City. Nurses from all over the world will be making stupendous efforts to find the necessary money to attend these sessions. Not since 1929 has an opportunity been afforded for so many Canadian nurses to attend this international nursing assembly. Begin now to make your plans to be there in May, 1947.



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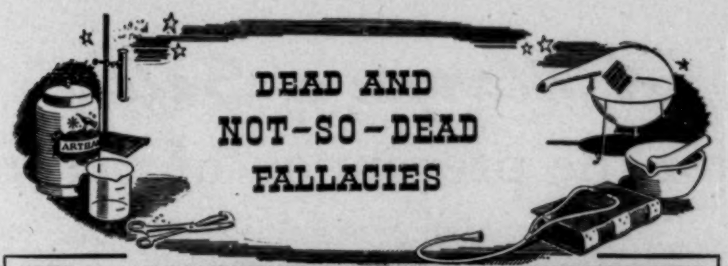
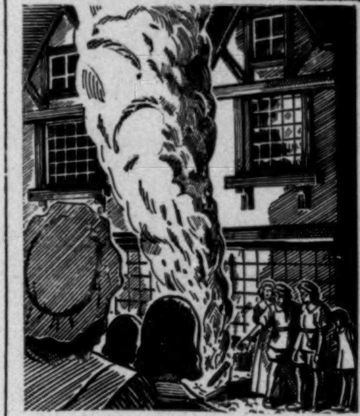


DEAD AND NOT-SO-DEAD FALLACIES



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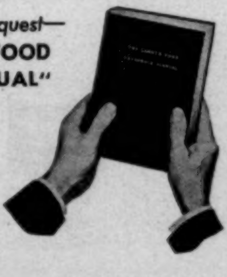

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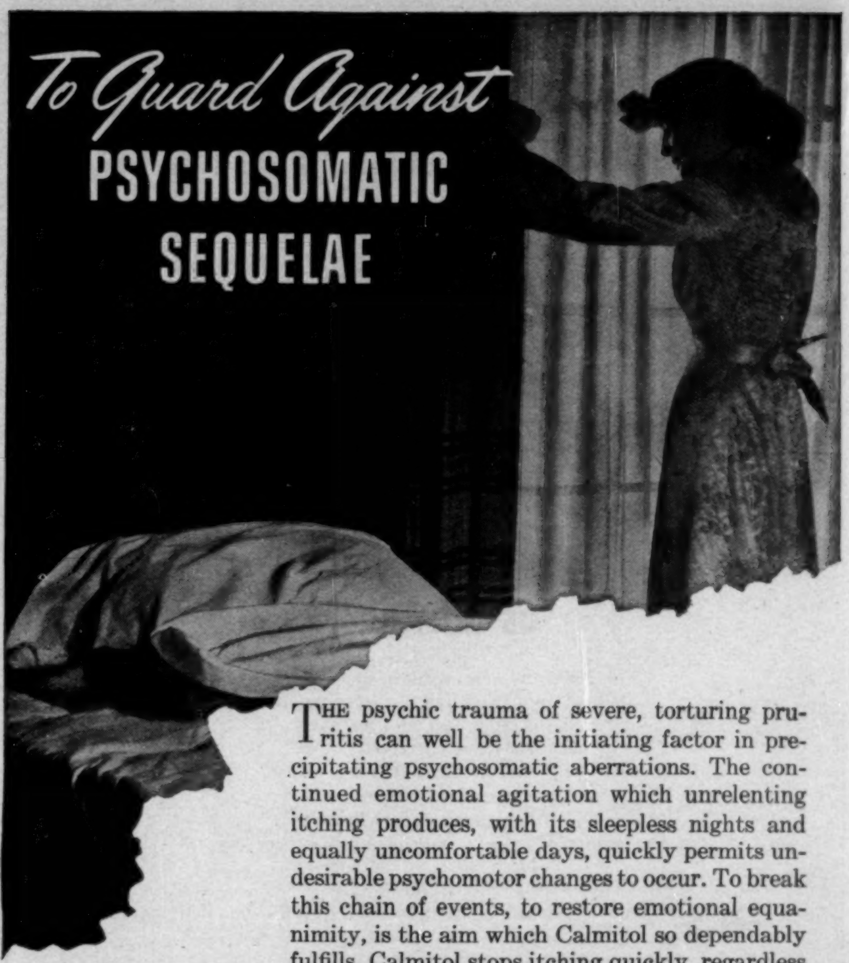

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The CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA
PUBLISHED BY THE CANADIAN NURSES ASSOCIATION

VOLUME FORTY-TWO *NUMBER TWELVE*

MONTREAL, DECEMBER, 1946

Merry Christmas

DECEMBER, which brings with it the most festive season of the year, also closes Volume 42 of *The Canadian Nurse*. A busy year in nursing activities is reflected in the thousand pages that make up this volume. This year has seen the return of our nursing sisters to civilian life. By their hundreds, they have thronged to our university schools of nursing to secure post-graduate training in order to fit themselves more adequately to meet their new experiences. The biennial convention brought nurses from all parts of the Dominion together to rekindle their professional interests. It has been a good year.

And now Christmas is approaching, the happiest Christmas many of us have known for many a long year. Already, the choirs of student nurses in hospitals all over the land have been practising the carols with which they will greet their homesick patients early Christmas morning. St. Francis of Assisi is credited with having been one of the first to popularize the custom of singing carols at Christmastime. He taught his followers simple and tuneful melodies and the story goes that, overjoyed by the success attending his presentation of the first Christmas Crib in 1223, he burst into joyous vocal recitation of the gospel story. Puritan England forbade the public singing of carols together with other forms of Christmas festivities. The irrepressible urge to sing was revived in the latter part of the seventeenth century when many of our well-known carols were introduced. Lighted candles were placed in the windows to welcome the carollers.

The use of greenery for decorations at Christmas antedates the Christian era. In honor of their gods, the early Romans were wont to fill their temples and dwellings with green boughs. When the custom developed in England, they used not only the evergreens but introduced holly, too. Thus, the red berries mingled with the green, added warmth and cheer to the decorations, and green and red remain our favorite Christmas colors. Legends dating from the Druids tell us that holly was abhorred by the evil spirits. When it is placed on the doors and windows it is supposed to fend off all these unwelcome visitors.

The centre of attraction in the hospital wards as in our homes is the Christmas tree. Trees used most commonly are the spruce, fir, hemlock, and pine. All of them tend to drop their needles, spruces more quickly than the others. In the warm room, the tree will hold its needles much longer if it is standing in water. A pan in which the water can be replenished should be placed in the base of the treestand. Pines tend to be unsymmetrical but make beautiful, long-lasting trees when they can be procured.

In ancient Britain, the New Year began with the celebrations on Christmas Day. William the Conqueror changed it to January 1 to commemorate the day on which he was crowned. This led to the belief that whatever was done on New Year's Day was a forecast of events for the year to come. In keeping with this legend, then, we wish all our readers not only the merriest of Christmases but a Happy and Prosperous New Year.

—M.E.K.

1946 Index

For the past two years, the Index of all material published in the *Journal* has been printed as a separate booklet. As soon as the copies were available, one was mailed to each subscriber. This year the Index will be printed separately but, in order to conserve paper, it will not be distributed to each name on the mailing list. Instead, special cards have been printed which will be found tipped into this issue. All you have to do in order to receive a copy of the Index will be to fill in your name and address and drop the card into the mail-box. We will pay the postage on these cards when we receive them. (If a second copy is required just indicate this on the card.) Copies of the Index will be available in the New Year. They will be mailed, without cards being sent, to all hospitals, universities, and libraries on our mailing list, as well as to the offices of the provincial registered nurses' associations. Individual subscribers are asked to forward the special cards as quickly as possible so that we may have some estimate of the number of copies of the Index that should be ordered.

Coming Event

The annual meeting of the Saint John Chapter of the New Brunswick Association of Registered Nurses will be held at the Saint John General Hospital on January 20, 1947. Note the date on your calendar now so you won't forget about it.

Primary Tuberculosis

G. F. KINCADE, M.D.

SINCE THE BEGINNING of the century, as a result of extensive case-finding and control methods, there has been a gradual reduction in tuberculous infection amongst the population. Whereas universal infection of the adult groups used to be the rule, this is not so today, and the majority of persons, especially the young adult groups, are not infected.

Results of tuberculin testing of students in universities throughout Canada and the United States show a gradual reduction in positive reactors. At the present time, the incidence reported is between 20 and 30 per cent. Among the students at the University of British Columbia in 1944, only 13.3 per cent of over 1,100 tested showed positive tuberculin reactions. Seven years ago, 40 per cent were positive. Each year has shown a gradual reduction.

It is only in the last decade that the designation, Childhood Tuberculosis, has been replaced by Primary Tuberculosis to indicate a first infection. This, in itself, is evidence of changing concepts and the knowledge that, whereas first infections were always considered to occur in childhood, we have now reached the phase where first infection tuberculosis is often seen in adult groups.

The type of response to tuberculous infection in the body will depend on whether or not the body has been sensitized by a previous infection. Broadly speaking, if the seed is implanted on virgin soil, a benign process is the result; if the body is sensitized by previous infections, a destructive process results. Formerly, we could safely assume that when a tuberculous process was discovered in the lung of an adult, this was a reinfection type of disease, hence a malignant process. That reasoning is now somewhat changed.

With mass radiography and close follow-up of young adult groups, such as student nurses, university students, high school students, and young people in industries, a good many primary lung lesions are being uncovered. Since we know that universal infection is no longer the rule we must be on the lookout for primary lesions in older age groups. With large numbers of persons in the armed services found to have tuberculosis, it is safe to assume that a certain proportion of these represent a primary type of disease.

The diagnosis of Primary Tuberculosis of the lungs in adults is not easy. In fact it is very difficult to make the diagnosis, with certainty, without a record of previous tuberculin tests. If the tuberculin reaction has changed from negative to positive during the six to twelve months preceding the finding of the lesion, it may be a primary tuberculosis. However, there are certain characteristics of the disease which, when present, should direct our thinking towards Primary Tuberculosis. In children the diagnosis is more simple and, as it is with this group that we have had most experience, we should depend on that to give us an understanding about a similar infection in the adult.

First infection tuberculosis usually occurs in the lungs by inhalation, although entry through the gastro-intestinal tract by ingestion is not uncommon. In any event, the reaction is the same, with inflammation at the site of implantation and enlargement of the regional glands. In the lungs, this is represented by a small area of bronchopneumonia. There is usually a single focus but multiple foci may occur. The centre of the focus caseates and the bacteria and toxins are drained to the regional lymph glands, in the hilar areas, and the glands become enlarged. The primary focus and the enlarged glands together are known as the primary complex. In this respect, primary and reinfection types of tuberculosis differ. In the reinfection type, the regional glands are not usually enlarged.

In the vast majority of cases, the primary infection is controlled when it reaches the glands and the process does not extend further. The hilar glands subside and return to normal size, while the lung lesion heals with a small fibrous scar or a spot of calcium in the area of the original infection. Similarly, the involvement in the hilar glands will show calcification. This is a normal response to a first infection and we can safely assume that the large majority will react in this manner and that the foci will remain well healed. However, some persons, for reasons considered to be due to lower resistance and poor general health, virulence of disease, or repeated heavy infections, will develop a progressive type of disease which will assume the characteristics of the reinfection type of tuberculosis and will need to be treated as such.

These complications of primary tuberculosis are the conditions usually seen clinically and for which treatment is necessary. The commonest complications are those due to involvement of the hilar glands and it is generally found, especially in children, that the reaction in the hilar glands is much more pronounced than that in the parenchyma of the lungs. As a result of this glandular involvement, the chief complications are: (1) atelectasis; (2) rupture of the hilar glands into a bronchus; and (3) extension along lymphatic channels to the circulatory system with hematogenous spread of the disease.

The atelectasis is usually due to pressure of the enlarged glands on a bronchus, cutting off the air supply to a lobe or lobule of a lung, and resulting in collapse of that area. The atelectasis in itself is a benign process but in the x-ray picture it is the predominant feature, having the appearance of a pneumonic consolidation, likely to be diagnosed as tuberculous pneumonia if the mechanism of its production is not understood. When the swelling of the glands subsides and the bronchus is no longer obstructed, the atelectatic area will re-expand with only the original lesion showing in the x-ray picture. However, one possible complication of atelectasis, especially in the presence of infection, is that of bronchiectasis.

The rupture of tuberculous glands in the hilus is, of course, a most serious occurrence and gives rise to widespread disease in the lungs. When the glands rupture into a bronchus, the disease may then spread directly to all parts of the lungs and cause a massive involvement of the parenchyma with tuberculous bronchopneumonia. When the disease extends along the lymphatic channels to the circulatory system, a hematogenous spread occurs with widespread tuberculosis throughout the body. Meningitis, nephritis, and other forms of extrapulmonary disease result, as well as the typical miliary distribution in the lungs.

Another complication is that of the progressive primary lesion in the lungs which tends to spread and excavate. This is a most unusual occurrence following a primary infection and when it does occur, is, in effect, a reinfection type of tuberculosis and should be treated as such. It usually occurs in Indians or Negroes or as a result of poor resistance and massive infection.

Other complications in the lung are pleurisy with effusion and tuberculous empyema. It is widely accepted that ideopathic pleurisy is almost always tuberculous and is very often the result of a primary tuberculous infection. There is usually a small area of infection in the lungs, not often detected, just under the pleural surface. Tuberculous empyema does occur but is not a frequent complication in this phase of the disease.

With the experience of primary tuberculosis in childhood and the knowledge that it is a benign process, what of the similar condition now being discovered in the adults? It is important to recognize and understand this condition. Its treatment and prognosis vary greatly from that of the reinfection type. Primary tuberculosis is benign and tends to remain healed, whereas the reinfection type of tuberculosis is a malignant process, tends to breakdown, and is very liable to reactivation even after it has become arrested.

The experience gained in primary tuberculosis in adults has been mostly with student nurses' groups because these are being followed closely. It has been the custom to tuberculin test student nurses before they enter training and every six months thereafter while they remain negative. This group is also x-rayed annually, since tuberculosis has become a compensible disease for hospital employees under the Workmen's Compensation Board in the Province of British Columbia. If the tuberculin test becomes positive, more frequent x-rays are taken. The majority of these nurses show no x-ray evidence of tuberculosis. However, even without radiological findings, it is felt that persons having a recent infection should be removed from the source of infection to a place where there is no danger of further contact. Immediately after the infection has taken place, there is a period of increased susceptibility while the infection is being controlled in the body. After the infection has healed, in a few months, those with a healed infection have a greater resistance to tuberculosis than before but by no means a complete protection against large and repeated reinfections.

There is abundant evidence to show that nurses entering training with a negative tuberculin test develop tuberculosis much more frequently than those entering with a positive reaction. To minimize the hazard, it would seem advisable that a student nurse, developing a positive tuberculin test, should be given two months off duty to carry her over the period of increased susceptibility.

In the infrequent case that shows radiological evidence of a pulmonary lesion of a primary type, the routine of sanatorium treatment is not usually necessary. If the lesion is small and remains localized and there are no clinical signs of activity, removal from duty and a modified rest regime, with limited activities at home, for a few months is all that is necessary. However, if the patient has clinical symptoms or if the lesion tends to increase in extent, a period of sanatorium treatment is indicated.

With still further reduction in tuberculous infection, it is safe to assume that we shall see primary tuberculosis more frequently. Mass radiography is being expanded and if the objective of annual chest x-rays for everyone is reached, the majority of new cases found should be of the first infection type. Early supervision of these cases and removal from further infection will prevent the complications that occur. This is the goal towards which we are striving.

Should Student Nurses have Experience in Tuberculosis Sanatoria?

MABEL SHARPE

TO HELP YOU UNDERSTAND some of the nursing needs in sanatoria for the treatment of tuberculosis, I am quoting from the annual report of the Mountain Sanatorium, Hamilton:

> Unfortunately, during the last year we have been so hampered by shortage of staff that it has been most difficult to carry out the complete program of previous years, and the decrease in work has been shown in many ways but chiefly in the decrease in chest surgery.
>
> It is becoming very apparent that the inability to carry out surgery in every case where it is indicated is very much to be regretted because of its importance in closing

cavities and thus in eventually being able to discharge patients with sputum negative for tubercle bacillus. Statistical studies tend to demonstrate the fact that cavitation in the lung is synonymous with sputum positive for tubercle bacillus, and this has resulted in the establishment of a sanatorium routine which attempts by progressive steps to use surgical procedures as an aide to the closure of cavities. Proceeding from nature's method of healing by rest the various steps attempted in an average case are:

(1) Compression by pneumothorax; (2) immobilization by phrenic nerve paralysis; (3) pneumonolysis or cutting of adhesions to permit satisfactory compression by pneumothorax; (4) compression by thoracoplasty.

These problems are the basis of study carried on at weekly staff conferences with the result that practically the whole routine of treatment is agreed upon after a careful study by the whole staff, thus ensuring that no surgical interference will be attempted unless in the opinion of the majority of the staff it is definitely indicated.

It has been pointed out that, from a purely financial angle, it was to the advantage of the patient to have a thoracoplasty performed as it decreased the length of stay in hospital and returned the patient sooner to gainful employment.

The average time for a complete course in treatment in sanatoria in the Province of Ontario for patients who were discharged or died was 386 to 403.6 days. Please note that this is not the average days' stay for all patients, just those who were discharged and died. In some of the sanatoria in Ontario, wards or units have had to be closed due to the lack of nursing services. The number of patients waiting for admission has increased and there has been a decrease of treatment days. There was also a decrease in surgical procedures. This is all directly related to the closing of beds due to lack of personnel.

Only a very limited number of student nurses receive affiliation in tuberculosis nursing. It would seem that the first problem to be considered is in the schools of nursing. Is the administrative staff meeting its responsibility in seeing that the student nurse who enters the school is given clinical experience in all of the basic subjects of a well-rounded course in nursing, which should include tuberculosis nursing? We hear that the consent of parents has to be obtained before this affiliation can be given to the student nurse. Do we obtain the consent of the parents before the student nurse attends pneumonia patients, septic throat cases, gonorrhea, syphilis, or other infectious cases? Right there, fear of tuberculosis is being instilled into the mind of the student and her parents.

In the general hospitals all patients do not have chest x-rays, and the undiagnosed case of tuberculosis may be cared for by the student nurse for some time before it is discovered. I well remember a patient with an acute appendix who was admitted for surgery. After a week of acute post-operative nausea and vomiting, it was discovered that the patient had far advanced pulmonary tuberculosis. In the meantime six student nurses had been exposed. In sanatoria all patients are treated as infectious cases from the moment of their admission. The nurse is protected. If you knew how many tuberculous patients ride buses and other transportation facilities you might feel less happy in boarding a crowded bus, street-car, or train.

One fallacy which is dying a slow death is the one concerning the lack of ambition in the nurse who nurses in a sanatorium. Another is that it does not require graduate staffs to nurse tuberculosis cases. If such a thing were possible, I would staff all sanatoria with nurses who have had a post-graduate course or affiliation in tuberculosis nursing. Tuberculosis patients are sick physically and mentally. They are long-term cases, and present a challenge to the nursing ability of every nurse.

If the term "sanatorium" could be forgotten and the term "hospital" be applied, the average nurse would have a different reaction to tuberculosis nursing. The term "sanatorium" is frequently associated with convalescent or chronically ill patients. Our patients are ill just as the pneumonia case is ill. There are the acutely ill—the far advanced cases; the not so ill—the moderately advanced active cases; the lesser ill—the minimal active cases; some improving, and some nearing discharge. Then there are the pleurisy with effusion cases and the non-pulmonary cases such as hip, joint, and spine involvements. There is the same satisfaction in seeing your patient recover as in a general hospital.

There are the various operative procedures such as thoracoplasty, monaldi, cavernostomy, phrenic crush or phrenic interruption, pneumonolysis, bronchoscopy, laryngoscopy, lobectomy, pneumectomy, which introduce a new and interesting field of nursing. Nurses express surprise that we should have special diets. We have diabetic diets, bland diets for intestinal cases, soft diet for throat cases, nephritic diets, as well as the general and light diets.

The nurse who does not know tuberculosis nursing influences the young student or young graduate against nursing in sanatoria. There is a definite need to educate the nursing profession regarding the tuberculosis field which is varied and interesting.

Then, too, there is that most important phase of the work—public health and prevention. The nurse needs a knowledge of tuberculosis nursing before she can carry on her work in a generalized public health program. Where is the nurse to secure this experience if not in the sanatoria as a student or as a young graduate? Is it not time that we faced the situation with an open mind, forgot or overcame our fears and prejudices, and introduced nursing in tuberculosis into the basic training of our student nurses? Only then will the patients in our sanatoria be able to receive the necessary nursing care and treatment which they have a right to expect and receive. Tuberculosis is a curable disease if discovered early. The length of stay in hospital is controlled by the care and treatment the patient receives which in turn is controlled by the number of nurses on the staff.

The average student nurse on admission to the school of nursing knows very little about the various fields of nursing or the subjects, both practical and theoretical, included in the curriculum. Her attitude to the profession is moulded by the classroom instructress, the ward supervisor, the head nurse, and the graduate floor duty nurse, and indirectly by the superintendent of nurses who has not the same constant close contact with the student. Is it not the responsibility of the graduate staff in the schools of nursing to see that the student nurse is made tuberculosis nursing conscious and that the directors of the schools make clinical experience in tuberculosis nursing available to all student nurses?

"As doctors and nurses we are now realizing that we are not caring for the physical aspect of disease but that we are caring for people, endeavoring to keep them in the best possible health —physical and mental."

Who Will Help?

One of our outstanding Canadian nurses, Miss Norena Mackenzie, who has served with UNRRA for some years, is giving an orientation course in present-day nursing practice to a group of nurses engaged in hospital work. In this group are thirteen Austrian and ten Greek nurses. They are exceedingly interested in our Canadian curriculum guides. Miss Mackenzie would like to present each of these nurses with copies of our *Proposed Curriculum for Schools of Nursing in Canada* and *A Supplement to a Proposed Curriculum*.

Any Canadian nurses who are not using their copies of either or both of these volumes, and would like to donate them, are asked to mail them at once to: Canadian Nurses' Association, 1411 Crescent St., Montreal 25, P.Q. Responsibility for forwarding these gifts will be taken by our National Office.

Bacillus Calmette-Guerin: A Weapon in Tuberculosis Warfare

LAURA I. M. COLEMAN

TUBERCULOSIS TAKES a terrible toll from every community in Canada. We must be seeking and striving for means of control in this dread disease. Robert Koch discovered the tubercle bacillus in 1882. From that day to this, and on into the future, the medical profession and all those associated have been searching, and will continue to search, for a means of protecting human beings from it.

One of the sought after protective weapons has been that of inferring a degree of immunity or resistance. The reason for this being a much desired goal is that it is doubtful if we can hope to totally eradicate the infection from the community. The disease cannot be exterminated; it can only be made minimal. Hence we must find means by which we can fortify our bodies against the inevitable exposure.

A vaccination material has been sought, based on the principle that certain bacterial diseases render the patient relatively immune against further attacks of the disease. We know that an artificial, mild, and controlled first infection creates an increased resistance to subsequent natural infection. A well-known example of this is the popular vaccination of children against smallpox. In this case the vaccination material is the virus of cowpox. Tuberculous vaccination is based on the Koch phenomenon. This consists of the observation that the inoculation of a guinea pig, already suffering from a generalized tuberculous infection, with a second dose of tubercle bacilli, will only result in a localized lesion. This changed manner of reaction by a previously infected animal, in contrast to the spreading generalized first infection, is interpreted as an expression of the presence of a degree of immunity in the tissues as a result of the primary infection. This immunity sets into action mechanisms created by the first infection which localize and prevent the spreading of the super-infection.

Various methods of immunization have been tried. Extracts of all types made from the tubercle bacillus have proven unsatisfactory to date, though there is no doubt that in some one fraction of the bacillus the immunity stimulating factor exists; but as yet this search has not been successful. Killed bacteria, not extracted, have experimentally produced an immunity of short duration, variable, and often doubtful. The only immunological procedure left is by way of living bacteria. Since 1882, there have been recorded the histories of some adventurous persons who created immunity by the use of living virulent human tubercle bacilli in fractional doses. But the use of virulent organisms as a routine procedure cannot be advocated because of the hazard of creating a clinical infection and perhaps losing the patient. The search thus had to be for an avirulent, yet immunizing organism.

The nature of the Bacillus Calmette-Guerin (BCG) must be clearly understood. No immunity against tuberculosis has yet been produced artificially in man by any other means than that of introducing living tubercle bacilli into the body, in a manner which will create a primary complex. This consists of the typical lesion, the tubercle, plus involvement of the lymph gland draining the region where the infecting organism gained entrance to the body and caused tissue destruction. BCG is neither a serum nor a toxoid substance: it is a vaccine of living but avirulent tubercle bacilli of the bovine type. This cattle strain was developed to its present state by cultivation on artificial media for a period of time. At the end of this it was found to have lost its virulence for cattle. This was hailed with great acclaim since in moderate doses the bacilli of one species are not pathogenic for another. This meant that a culture had been found which was not only non-human but incapable of causing a generalized diseased state in its natural species; hence, as in the story of Jenner and his smallpox vaccine, protection might be given to man in small measured doses.

This question, which has survived the vicissitudes of twenty years' stern appraisals, and is gaining supporters, may be of prime concern in a not far off future. In the past, heavy accusations have been levelled; these I do not intend to go into for in recent years these are no longer substantiated and may be largely regarded as the unforeseen difficulties of every new enterprise in medicine and which must be overcome as they occur. For one thing, the early cultures were not stable and were not a *virus fixée* as Calmette thought. It is to the Swedish worker, Wassen, in Gothenburg, that the greatest credit goes for creating a reliable vaccine. This might seem an easy task, but papers published prior to ten years ago speak of it as an almost impossible hope.

The strongest advocates of the positive value BCG can have in preventive therapy are the Scandinavians. Now that the world has ceased its warfare it has been possible to at last hear of six years' further studies. It is interesting to note that their enthusiasm has remained as vigorous and unremitting during the difficult period as in the years of peace. They recognize as recently as January, 1946, that still the BCG strains distributed all over the world are not of constant and uniform virulence and earlier Pasteur Institute strains were more virulent. That is to say, only at Gothenburg in more than seventeen years of painstaking juggling of cultures and media has one laboratory achieved uniformity, consistency, and safety. In connection with this acknowledgement it has been suggested that, with modern facilities of transportation, it would be better to consider the Swedish laboratory the only standardized source for reasons of safety and comparison.

To Walgren, the professor of pediatrics at Gothenburg, goes the credit for clinical application. He laid down the general principles which must be followed if BCG is to be a successful immunizing agent:

1. Only those persons negative to tuberculin must be injected—with the proviso that a minimum of six to twelve weeks prior isolation from possible tuberculosis contact has been carried out (this being the duration of the pre-allergic phase in spontaneous tuberculous infection).

2. Tuberculin allergy must follow injection; until this becomes manifest (in about six weeks) the individual must be again protected from virulent infection. (In some children, allergy to old tuberculin cannot be created despite several BCG vaccinations, as many as four attempts being unsuccessful.)

3. If, after eight weeks, the tuberculin reaction is negative, the dose must be repeated, or a higher dose given.

4. The injection is made into the skin of the thigh or upper arm. There are two routes of inoculation—oral and parenteral. Oral, which was used only in young infants, has been discarded on three grounds: (a) the number of tubercle bacilli entering the tissues cannot be estimated although a measured dose may be administered; (b) a primary complex in the ileum and mesenteric glands cannot be inspected; (c) in the hands of certain American workers the number of tuberculous deaths with oral vaccination was half the control death rate, while with parenteral vaccination the rate was one quarter that of the control mortality.

5. General health measures must not be neglected.

A measured dose of BCG is introduced into the skin, and a primary focus forms at the site with subsequent involvement of the regional gland. It is considered that the skin being an insensitive tissue, this artificial and controlled primary complex is harmless to the subject, but at the same time is sufficiently potent to produce tuberculin allergy (positive skin test). One may think here of the feud that allergy and immunity bear no quantitative relationship, but it is our only yardstick, poor as it may be. Various workers are in agreement that tuberculin allergy and a minimal lesion can produce an immunity which protects against all forms of tuberculosis for several years.

When considering the value of BCG as a prophylactic measure certain universal generalities must be borne in mind:

(a) Some persons cannot develop resistance; (b) any level of resistance can be overcome by a sufficiently large dose; (c) in life, in contrast to animal laboratory work, we cannot control the frequency of nor quantity of organisms to which the person is exposed; (d) for the above reasons no figures will ever show 100 per cent success.

In addition, I wish to point out that in the study of individuals the proper selection of controls is difficult. Interfering elements include:

(a) Racial factors; (b) different exposure conditions from those of the vaccinated; (c) necessity of keeping in contact with all patients; (d) necessity for reliable diagnosis at death, i.e., post-mortem.

The difficulties are so great that in one report, when close random sample control was instituted, the preferential figure for the vaccinated group became negligible; this suggests that the children chosen for the control group, in at least this one study, were those with co-operative and intelligent parents rather than others. On the other hand, in Scandinavian reports where there is today great difficulty in getting controls because vaccination is so popular, there is a record kept over ten years showing that of ten children whose parents refused vaccination five died from tuberculosis and one was ill with the same disease. Nine hundred and five were vaccinated and of these none died and there was a morbidity of 0.2 per cent.

The most recent conclusions in the literature, and those generally held, are as follows: Children who are vaccinated with BCG have a much smaller possibility of acquiring a tuberculous infection by contagion than the non-vaccinated. Up to the age of six, the frequency of infection in the vaccinated is lowered to nearly one-half. Also, in the vaccinated child there is a longer time between the actual exposure and the development of infection; furthermore, this infection tends to follow a more benign pattern.

In closing it should be stressed that, like all prevention, BCG should not be expected to accomplish more than other vaccinations, viz., where the protection is against casual contact with the disease, and strict isolation of known cases is enforced.

Queues and Waiting

GERTRUDE M. HALL

BRITAIN

WE THOUGHT we were pretty well prepared for the changes which war and its consequent havoc had brought to London, and we knew we would be saddened by these changes. We soon discovered, however, that no amount of reading, not even the frequent glimpses afforded by the weekly newsreels, could possibly give us the actual picture of the conditions which we were to encounter. We said to our colleagues: "One must see this to really understand and to appreciate what Britain has endured and is still enduring."

A news reporter called at our office recently and posed the question: "What were your general impressions of post-war Britain?" Our first and last impression is that of a people suffering from post-war fatigue—a fatigue which has penetrated so deeply into the lives of the population that its effect is reflected in every phase of life and living.

There are signs of destruction everywhere. While it is true that the rubble and debris have been pretty well cleared away, the scars and wounds are still there. Nature—bless her!—has her own way of relieving and softening the marks of tragedy and horror. Attending service at St. Paul's Cathedral the day following our arrival, we were deeply touched as we beheld the vast area surrounding the Cathedral which bears little or no resemblance to the St. Paul's and environs as we remembered them. A stroll through the streets after the service only served to deepen our feeling of despair as we witnessed the havoc wrought by war. While in this depressed state of mind we suddenly caught glimpses of purple and blue flowers which had sprung up here and there among the ruins. The air was fragrant with the perfume of sweet alyssum, which had no doubt been carried by the gentle winds and planted among the ruins and in the cellars of what once represented the foundation of a great commercial building, or perhaps a lowly dwelling. Green grass, moss, and ivy, too, covered the stones and rocks. Time has softened the blow; the healing process has begun. We pause and wonder—gradually our faith is restored. Surely! surely! this time we have learned a lesson, or shall we soon forget?

Retracing our steps, we wend our way into the heart of London—this time atop a London bus. Trafalgar Square, Regent Street, Oxford Circus, past Liberty's, Swan & Edgar's, Selfridge's—all familiar landmarks still there to greet us; the large show windows are often missing. We are fascinated with the artistry and skill displayed by those responsible for the window displays— a four-foot square of glass surrounded by a heavy framework of boards or canvas; a single piece of merchandise gracefully arranged attracts the attention of the passer-by. How like a window in a doll's house!

Homes and hospitals are visited and the same sad story is repeated. Varying areas of these domains are waiting patiently, waiting for repair. Restaurants, cafes, tea-shops, some we remembered as the pride of London. Not so now, alas! Repairs, replacements, and decoration are needed, urgently needed. Unmatched dishes; cracked and chipped dishes; no teaspoons; worn and faded tablecloths; no tablecloths; no table napkins, not even paper napkins; the menu dull, deadly dull and monotonous; food strictly rationed; fruit in short supply or not at all, and prices prohibitive for such as is available. Added to all this there is the weather, British weather, more so! Dreary and cold; rain—more rain—persistent rain; everyone complaining of the weather—a general annoyance at the lack of sunshine and summer weather—"no summer at all, Miss," the usual remark of the cab driver as he closes the door upon your departure.

Queues — more queues — women standing, waiting, a look of resignation as well as weariness, but still waiting. Britain is truly a country of queues and waiting. Surprising how little complaint or grumbling on the part of those who queue and wait! The people of Britain seem too weary to raise their voices in protest. Such stoicism! We marvel at their powers of endurance; perhaps it is easier now—no more sirens, no more bombs, but oh! the queues and waiting, will it ever end? Will the housewives—women worn until they look ready to drop—ever again experience the joy of normal shopping? How they long for the day when rations are no more and when there will be a choice of foods, when menu-planning will be something of a pleasure! We secretly ask ourselves whether we could endure these restrictions and hardships, and we secretly admit—we haven't got what it takes! The shopkeeper, the cab driver, the little nurse on the District, affectionately called by her families as "our Queen's nurse," are queried as to how they feel about their lot. The same reply from all—"We must export our goods; we must have money for recovery; we must wait a little longer for the things we need so badly." We feel so humble as we offer up a prayer that the waiting may not be too long.

"Not a very glowing picture," I can hear the reader exclaim, to which we reply, "The picture as we saw it was grim—desperately grim, but our admiration for the British was greater, if such could be, than ever before." It was comforting, at least, to learn upon our return that restrictions on the weight of food parcels from Canada had been eased and that we could continue to show our appreciation of all that has been done by increasing the amount and variety of food parcels and thus help to supply a few much-needed extras for an otherwise dreary diet.

The nursing situation in Britain, like that of every other country, is in a state of confusion: nurses in short supply, hospital beds filled to overflowing, long waiting lists of patients, health services expanding everywhere. The Ministry of Health, driven almost to desperation, has taken the matter in hand in a very practical manner and has set up a committee to analyze the nursing problem with a view to remedying the situation as speedily as possible.

The Ministry of Health appointed a Steering Committee to initiate a study of the nursing situation. This committee consists of the following: the Chairman, who represents the Ministry of Education; representatives from the Ministries of Labor, Health, Pensions, Board of Control Committee. The working party actually conducting the study consists of two nurse-members, a medical man, and a psychologist, who is also an economist. The working party will study the problems first, reviewing and analyzing all previous reports on nursing, such as the report of the Lancet Commission, the Horder and Rushcliffe reports, etc. Psychologists, assisted by a nurse, are carrying on a job analysis; a study of the present high wastage of students who cancel training for various reasons; the recruitment of student and assistant nurses; the structure of the nursing profession; methods of training; organization of personnel in hospitals and other institutions and comparative programs in other countries. We very much regret, however, that the report of this committee is to be treated as confidential, but we hope that it may ultimately be possible to obtain certain statistical information, particularly as related to the wastage of students.

Several of the large London hospitals are still operating Sector Hospitals. These are situated some thirty to fifty miles from London and consist of emergency huts. Student nurses are frequently housed in a large private residence which has been taken over by the hospital. Preliminary students are taught in the preliminary training school in the Sectors, classrooms having been fitted up in one of the huts. All other classes are given in the main hospital in London. The administrative problems connected with these hospitals are many and extremely difficult. It was pointed out that although Sector hospitals were a sheer necessity during the war, they are more or less becoming an accepted measure, and the burdens of the administrators show little, if any, sign of being lessened.

HOLLAND

We were privileged to visit Holland, where the Nurses' Association of the Netherlands did so much to make our visit interesting and profitable. The Netherlands are rapidly getting back to normal, and indications are that sooner than was originally expected tourists will be able to enjoy the traditional hospitality of that famous little land of old-world charm and modern progress. The scars of war, which marred beaches, the dunes, and the inundated areas are rapidly being erased. The lovely woods and lakes of Holland will soon beckon the visitor with the same irresistible allure which made her justly famous as a tourist centre of world renown. Here, too, we found the food supply more abundant than in Britain—fruit and vegetables were available in quantities.

Our itinerary included visits to The Hague as guests of the director of nursing of the Municipal Hospital. Amsterdam, known as the Venice of the North with its tree-shaded canals, afforded us a very pleasant visit, where we were guests of the matron at the Antoni Van Leenwenhock-Huis. We managed to steal away for a delightful sail through the canals on the motor-tram—a novel experience, indeed, and one that will not soon be forgotten, for did the sun not shine in all its glory? Indeed, it smiled upon us every day during our visit to Holland. We were forced to conclude that Holland is a country of sunshine and flowers—flowers, flowers everywhere—the golden marigold replacing the famous tulip at that season of the year, dahlias, roses, asters, and goldenrod blooming in profusion everywhere.

A little excursion on the Zuider Zee took us to the Island of Marken, where we proceeded to the fishing harbor of Volendam. The Volendam costumes, both of the men and the women, are particularly picturesque in their local peculiarities. The fishermen themselves are fine fellows and their hale and weather-beaten countenances are well suited to their dress.

Back in Amsterdam we visited various hospitals, including the Midwives School, which is a State school for the training of midwives and has an excellent record. The orthopedic hospital at Nijmegen was one of the most modern of its kind. Every facility has been provided and it is the envy of other hospitals.

A nurse's training in Holland consists of three years' general training plus six months' specialization in midwifery and one year in pediatrics. The State registered nurse's pin is given on successfully completing a three-year general training; when the certificate in midwifery has been obtained the figure of the stork is added to the pin; two stars are added for certification in pediatrics. If a general trained nurse wants to obtain a diploma in mental nursing, she must spend eighteen months in a mental hospital where, in addition to clinical experience, she receives classes in mental nursing; these include, psychiatry, neurology, anatomy and physiology, and mental hygiene. Upon successful completion of this course she has a blue cross, silverlined, added to her State registered nurse's pin.

The nurses of Holland, in common with nurses of other lands, have made a very great contribution to the war effort. They have suffered much, but spend little time discussing or reminiscing on the past. Many are anxiously awaiting the opportunity to visit other countries, to study and learn abroad. Many have their eyes turned toward Canada, and we share their hope that, before too long, we may work out a plan for the exchange of nurses, as only by such experience can we really understand and appreciate the customs and problems of other lands.

Pre-Frontal Lobotomy

ELIZABETH K. MCCANN

ANY OPERATION on the brain or its tissues is always of especial interest. Neurosurgery was comparatively unknown until the beginning of the twentieth century. Today, it is a highly specialized branch of surgery. It demands nursing skill of a very high order, given by nurses who thoroughly understand the problems involved and who can provide the quality of care and the detailed observation, so essential to the recovery of the patient.

DEFINITIONS

The cerebrum, the largest part of the brain, consists of right and left hemispheres, each of which is divided into five lobes: frontal, parietal, temporal, occipital, and insula. The frontal lobes are essential for satisfactory social adaptation. Some individuals suffer from perverted activity of these lobes and are improved, socially, when these lobes are partially inactivated.

Partial separation of the frontal lobes from the rest of the brain has three principal results. There is a reduction in the degree of disagreeable self-consciousness; obsessive thinking is abolished; a feeling of satisfaction with performance is established even though it may not be on as high a level as previously. The operation, as yet, is reserved for those patients whose outlook for recovery is poor, whose response to other treatment is unsatisfactory, and those who face disability or threaten suicide.

A pre-frontal lobotomy may be defined briefly as an incision of the fibres connecting the thalamus and the pre-frontal region which results in the degeneration of the cells in that area. The alteration in the emotional responses of the individual follows upon recovery.

CLINICAL MANIFESTATIONS

In general, patients who are suitable subjects for a pre-frontal lobotomy have definite and troublesome psychoses. Many are paranoidal, with delusions of persecution. Some are manic depressives and suffer from a profound depression. Some have been hebephrenic with absurd compulsions. Whatever the particular form their aberration may take, these patients have grossly abnormal behavior to their own detriment. The suggestion of one experimenter that criminal minds might become more socially acceptable has not, as yet, been pursued to any definite conclusion.

The following psychotic manifestations may be observed in these patients:

(a) *Persecutory delusions:* Suspicion of attempts of poisoning by the family; fear that aeroplanes are spraying gas, etc. These people take offence very readily and tend to be suicidal.

(b) *Obsessions:* A common illustration is seen in the person who suspects contamination and who washes the hands constantly; or one who demands perfection and checks and rechecks accounts or money incessantly.

(c) *Hebephrenia*, which is distinguished by silly grimaces, foolish and ill-timed laughter.

(d) *Autonomic:* This shows itself in extreme self-absorption; the persons so affected are marked hypochondriacs.

(e) *Visceral:* There are continual and unwarranted complaints of indigestion, palpitation, stomach trouble, intestinal irregularities; multiple major surgery is common.

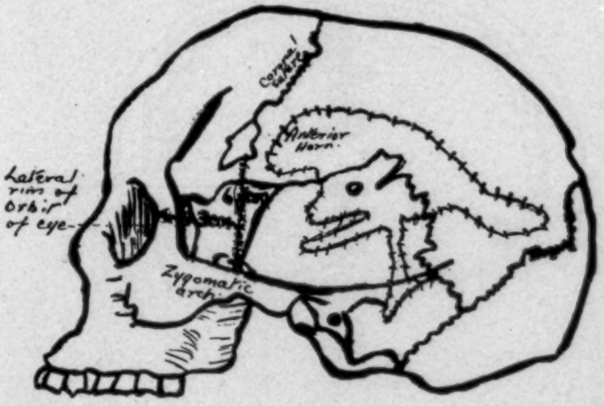
The individual retrogresses to the point where the immediate family becomes aware that treatment must be received. Many of the patients are the asthenic type, very egocentric. Some have been sluggish, catatonic; others restless and tireless to the extent of exhausting themselves. All show some form of nervous tension, anxiety, and apprehension. The physician may try various treatments such as metrazol, insulin, or electric shock. If these yield no result and the symptoms persist or deepen, surgery, "psychosurgery", is indicated.

PRE-OPERATIVE PREPARATION

The first essential is to secure ***written permission*** for the operation. If the patient is sufficiently responsible, he should sign. In addition, at least one and, better still, two of his immediate relations should be asked to give their written consent.

A ***full explanation*** should be given to the family of the adjustments that will have to be made. They should be told that while the operation may solve one problem it will probably add others temporarily. The patient will be confused and disoriented for a time if the operation is successful. He may recognize his own family but no others. He will be incontinent for a varying length of time. His initiative will be reduced, so special care during convalescence is extremely important. Feeding, dressing, bathing, toilet habits are all difficult for a while. The patient will be crudely frank, tactless, and obstinate but may be readily distracted. The care will require a tremendous amount of patience on the part of the family. Where available, a special nurse or a well-qualified attendant can be of great assistance to the family after the patient is discharged from hospital.

The patient is admitted to hospital the day previous to operation. Regardless of the anesthetic to be used, he is given a cleansing enema and sedation at bedtime to ensure a good night's sleep. In the morning, he is not given breakfast; he is given codeine sulfate an hour and a half pre-operatively. Local preparation entails shaving of the temporal and frontal regions. It is done one hour pre-operatively but if the patient is agitated it may be left until after the anesthetic has been started. For a general anesthetic, avertin is used, preferably administered by the ward nurse or the patient's own nurse.



Drawing showing marking and measures from specific points.

In the Operating-room

On the table, the patient is placed in the supine position. The table is tilted slightly toward the feet to favor venous return and to reduce venous oozing. A sand-bag may be placed under the head in order to flex it.

If the operative area has already been shaved, it is cleansed with green soap, ether, iodine and alcohol, or green soap, ether, bichloride of mercury, 1:1000. The hair may be held back with a rubber dam and adhesive if desired or necessary. The coronal suture and the area of incisions are marked with gentian violet.

The anesthetic may be local or general, depending on the patient's and the surgeon's preference. For research purposes, local anesthetic is preferred. Intratracheal anesthetic is highly satisfactory.

Operative Technique

The coronal suture is located. It crosses the mid-line about 13 cm. behind the glabella (space between the eyebrows) and comes down 3 cm. posterior to the lateral rim of the orbit. A mark is made 6 cm. above the zygomatic process on each side.

A small, vertical incision, 3 cm. long, is made at the centre of the intersection. Identification of the coronal suture is made, then the surgeon cuts the skin and temporal muscle. He may require chisel and hammer to make an impression on the bone. Muscle is scraped back with a periosteal elevator. Bleeding is controlled with snaps and high tension coagulator and the mastoid self-retaining retractors are put in. A burr hole is made with a drill, "trephine." The dura is incised, a dura hook and knife being used. A rongeur may be used to enlarge the burr hole above and below. An incision is made through the avascular cortex. A marked brain needle is inserted to ascertain (a) the depth to floor of brain; (b) the distance to each side; (c) the location of the ventricle horn. Through this exploration, the surgeon ensures the avoidance of the central cerebral arteries.

A brain elevator is inserted the measured distance and gradually swung upward and downward in the plane of the coronal suture so that the end is not less than 1 cm. from the mid-line. This severs the connecting fibres of the white matter of the frontal lobe, the "association" area. The area is irrigated with saline until clear. In closing the opening, the dura may be caught with one or two sutures; the bone is put back; the temporal muscle, galea and skin are all closed with white cotton interrupted sutures or as the surgeon prefers. The procedure is then repeated for the opposite side.

The nurse's duties are outlined as follows:

(a) Have plenty of brain hemostats ready and hand them to the surgeon quickly.

(b) Be sure the high tension surgical unit is completely connected and convenient.

(c) Have plenty of gauze sponges available.

(d) Have syringes ready, well filled with saline when burring begins. Spray if required.

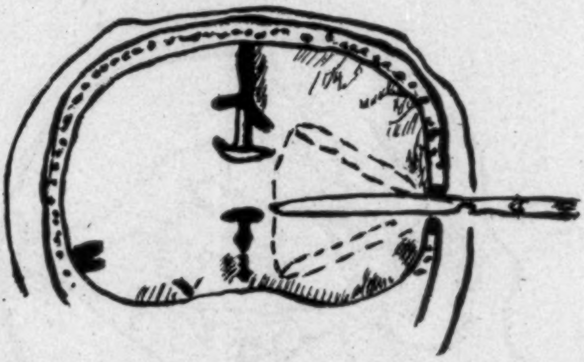
(e) Have sutures ready and up quickly.

(f) Remember—two dressings and sterile bandage.

The environment for brain surgery must be completely controlled. The rule of *absolutely no noise* means that instruments must be handled quietly; the sterilizer, the fan must be silent; the voice should be low if requests are necessary. The circulating nurse must be very alert at all times.

POST-OPERATIVE CARE

During the operation, the patient may vomit. This will stop spontaneously when the cutting of the white matter is complete. If the operation is successful, the patient should be drowsy, confused, and disoriented as soon as the fourth quadrant is cut. This can be elicited, if a local anesthetic has been used, by attempting to converse with him. If it is a research case, dye will be injected before the incision is closed. The patient is taken immediately to the x-ray for views to show the extent of the incision.



Drawing showing manner of incising white matter. Identical cuts are made in opposite lobe.

The patient is placed in a semi-Fowler position in his bed, with the head elevated to 30°. This is thought to reduce venous congestion and so prevent post-operative hemorrhage. The bed is left thus elevated for 72 hours unless the systolic blood pressure drops below 100. Should this occur, the bed is flattened until the blood pressure reaches 100, then is elevated again.

The blood pressure, pulse, and respirations are recorded hourly for twenty-four hours. Temperature is taken per rectum every two hours for twenty-four hours, then every four hours.

A special nurse is desirable for this type of patient because of the constant attention that he requires. If left alone, the patient, in his confusion, may get out of bed. He still may have suicidal tendencies. Elderly patients require frequent turning to prevent pneumonia.

Fluids are limited to 1000 cc. in twenty-four hours for three or for days. If nausea persists, intravenous saline, 500 cc. every twelve hours, may be necessary. For the first two days, the patient is on a soft diet and, since he lacks initiative, usually has to be fed.

There is usually very little pain. Codeine gr. 1 is adequate and seldom has to be given more than once or twice.

The nurse should be aware of the pre-operative symptoms the patient showed so that she can make comparisons post-operatively. Re-operation may be necessary if by the fourth or fifth day observations indicate the previous manifestations have not been removed.

Post-operative Results

Usually, the individuals demonstrate considerable change if the operation is successful. They have huge appetites and gain in weight. Their appearance improves. There is a levelling off of the impulses—restless individuals are no longer ceaselessly driven; sluggish persons show some activity. The degree of intelligence does not seem to be affected. The temperament usually shows a marked change. The individuals react vigorously, abruptly, even explosively, but show little depth of feeling. Anger is soon over and gone. Anxiety is abolished. Apprehension and nervous tension are no longer of any account. They can remember what bothered them but are no longer concerned or even interested. The egocentric individual tends towards extraversion. Over-sensitiveness and over-meticulousness are eliminated.

Generally speaking, the results show that imagination, initiative, and ability for planned endeavors are reduced. There is a "bleaching of self." There may be a drop in the blood pressure. Final results may be greatly delayed, necessitating much patience and persistence by all concerned. Results are encouraging on the whole.

You Will be Sorry!

Through the years, the practice has been followed of extending subscriptions to *The Canadian Nurse* beyond the actual expiry date. Nurses who had been subscribers for only one year actually received thirteen copies for the price of twelve if they did not renew promptly. Those who had been subscribers for two years or longer received two gratis copies. Poor economy on our part? Perhaps so, but it was done to prevent you missing any issues, if perchance it was inconvenient or impossible for you to pay your renewal promptly. This service has been appreciated by many of our subscribers who have expressed their gratitude that their receipt of issues was not interrupted.

Unfortunately, this practice has had to be stopped. Beginning with the November issue, we shall remove all name plates in the month of expiry, if the subscription is not renewed. We shall hope to have a sufficient supply of *Journals* on hand each month to take care of late renewers but we cannot send any more of these "baker's dozen" copies. The reason is two-sided. Today, our circulation is expanding more rapidly than ever before in the *Journal's* history. Unfortunately, the paper situation continues to be very much of a problem. We have had to reduce the size of the issues from eighty-eight to eighty pages excepting in the four months when the Official Directory is published. That still did not give us enough copies to supply the demand. We had only one other choice — eliminate the non-renewers promptly.

Renewal notices are mailed a full month prior to expiry. These are followed by a second and even a third notice. Avoid delaying! Remit your renewal promptly or you will be sorry!

Award of Merit

At the annual convention of the American Hospital Association held in Philadelphia on September 30, 1946, Dr. George F. Stephens, superintendent of the Royal Victoria Hospital, Montreal, was the recipient of the Award of Merit, presented by the A.H.A. for meritorious achievement. On the reverse of the medal is engraved:

> George Findlay Stephens, Royal Victoria Hospital administrator and physician, who through a distinguished career marked by integrity and devotion to human welfare has contributed outstanding leadership to hospitals in Canada and the United States.

Dr. Stephens is well known across Canada for the splendid contribution he has made through the Canadian Hospital Association. He was formerly superintendent of the Winnipeg General Hospital.

Memorial Hospital

Tribute was paid to the late Jean Matheson R.N., when the new unit of the D.V.A. hospital in Vancouver was opened recently and named the Matheson Memorial Hospital. This 150-bed unit will be used chiefly for patients with diseases of the chest. Miss Matheson was for many years the matron of Shaughnessy Hospital.

Contributed by Hospital and School of Nursing Section of the C. N. A.

Supervisor-Student Relationships

HELEN M. MANN

INTEREST IN THE NATURE of supervisor-student relationships as a factor in the student's learning and development as a professional person is of recent origin. Hitherto, we had given little thought to the complexities of the relationship and had assumed that when we assigned a student to work under a trained and experienced supervisor, learning inevitably took place. When this failed to happen we commonly placed the blame on the student—she was dull, or disinterested or, perhaps, even too flighty! It is only of recent years that we have become conscious of the many factors that encourage or limit a student's learning. Our recognition of these factors has influenced our supervisory practice to a great extent.

What then are some of the factors in the relationship between a student and a supervisor of which we should be aware? Or let me ask another question. What is the purpose of the relationship? Is it to get a job done or to make possible the student's learning? I am sure that we would all agree that the latter is our first responsibility as student supervisors, although the fact that students learn on human beings inevitably means that we have a responsibility to the job being done as well. How we reconcile these different responsibilities in individual situations would be meat for further discussion.

The feelings which the young student nurse brings to her training experience will inevitably influence her use of supervision. What are these feelings likely to be?

1. *Fear:* Will she be able to measure up to the many demands made on her?

2. A certain amount of *emotional conflict* as she encounters new experiences: death; the syphilitic patient on the ward; the unmarried mother who refuses to see her baby; the care-worn, malnourished mother who comes to the hospital to be nursed back to health, only to return to the same vicious set of circumstances that caused her breakdown. All these things make a terrific impact on the poise and balance of the young nurse. She will need a great deal of understanding and support from her supervisor as she struggles to come to terms with some of the harsh, uncompromising realities of life.

3. *Resistance:* Although the student has chosen nursing as her profession and is eager and enthusiastic to proceed with her training, all her feelings about becoming a nurse may not be positive ones. Most girls coming to a school of nursing are young and have not completely outgrown their dependence on parental care. Then, overnight, they are whisked into a setting where the nurse's control of her own feelings and her discipline of herself for the sake of her patient are common watchwords. This can be a highly threatening experience for the young

girl and small wonder if she sometimes wonders if this is really the road she wants.

Too, if she is like her sister who goes into social work, she sometimes wonders how much this experience is going to change her. She has heard that nurses are sometimes cold and callous to suffering and she does not want this to happen to her. If, perchance, her supervisor seems to be a cold, withdrawn person, the student's resistance to training and to supervision may be heightened.

These are only some of the feelings that most young students bring to their training experience, whether it be in nursing or in social work. Different students will, of course, experience them in different degrees and will express them in different ways. One student, for instance, may show her fear by being constantly submissive, showing no initiative and being completely unable to do anything without being told. Only as she gains some security with her supervisor and in her new setting will she be able to take hold so that real learning may take place.

Another student may handle her fears by being aggressive. She will take everything into her own hands, ask no questions, and be apparently unable to use her supervisor's help. This type of student can be very frustrating to supervisors unless we understand what is happening to her. We must realize, however, that unless we can give her acceptance and understanding we will only increase her insecurity and the behavior which makes her such a problem on the ward.

Space does not permit discussion of how we might handle specific problems that come up in student training. I can only emphasize the necessity of seeing these problems as they emerge, not as isolated incidents but as part of the student's whole problem.

In conclusion, may I point out that it is not only the student who brings feelings to the supervisor-student relationship that must be taken into account. Supervisors, too, have attitudes that must be brought under conscious control. Briefly, our whole feeling about our supervisory position and our use of authority are perhaps of greatest importance. Are we comfortable in a position that carries authority? Do we need to deny it or to make too much of it? A great many of our supervisory problems centre around this question of authority. Our need to completely control our students, to make them replicas of ourselves, and our need to have our students like us are some of the problems we must face.

These are only a few of the factors that enter into the supervisor-student relationship. It is hoped that they may be suggestive of further lines for thought and discussion.

Did You Forget?

Last May, Zoe Tsóukala, a leading nurse from Greece, was a visitor in Canada. She told us of the dire need of the nurses of Greece for footwear. We shared this information with you in a brief note in the July, 1946, issue of the *Journal*, urging the nurses of Canada to clear out their drawers and cupboards of stockings and shoes and mail them directly to Greece. Now, five months later, word has come from Miss Tsoukala that the Greek nurses are very disappointed — the footwear from the nurses of Canada *just has not arrived*.

Perhaps, it being vacation time, you did not read that message. Perhaps you thought all of the other nurses would be sending parcels, so why bother. Perhaps the heavy postage rate scared you. In any event, shoes and stockings are still sorely needed. The National Office of the Canadian Nurses' Association has volunteered to receive and forward your parcels. Bundle them up right now and send used shoes and stockings to Suite 401, 1411 Crescent Street, Montreal 25, P.Q.

PUBLIC HEALTH NURSING

Contributed by the Public Health Section of the Canadian Nurses Association

Sources of Health Education Material

Sheila MacKay

For the benefit of those in the public health field who are interested in obtaining pamphlets, charts, posters, films, film strips, lantern slides, etc., which would be of use to them in their health educational programs, we are publishing the following list of Canadian and American agencies from which such materials may be obtained. Unfortunately, we are unable to list the actual materials available, but the majority of the listed organizations will send catalogues or samples on request and the name of the organization is usually suggestive of the type of work which it does and, correspondingly, the type of material which it can supply. It was not considered necessary to list the Dominion or Provincial Departments of Health as they are well-known sources.

American Association for Health
Physical Education and Recreation
1201 Sixteenth Street, N.W.
Washington 6, D.C.

American Association of University Women
1634 Eye Street
Washington 6, D.C.

American Dental Association
212 East Superior Street
Chicago 14, Illinois.

American Hearing Society
1537-35th Street, N.W.
Washington 7, D.C.

American Home Economics Association
Mills Building
Washington 6, D.C.

American Institute of Baking
1135 Fullerton Avenue
Chicago 14, Illinois.

American Medical Association
535 North Dearborn Street
Chicago 10, Illinois.

American National Red Cross
17th between D and E Streets
Washington 13, D.C.

American Nurses' Association
1790 Broadway
New York 19, N.Y.

American Public Health Association
1790 Broadway
New York 19, N.Y.

American Social Hygiene Association
1790 Broadway
New York 19, N.Y.

APECS (News Bulletins of the Experiment in Applied Economics)
Room 6328
50 West 50th Street
New York 20, N.Y.

Association for Childhood Education
1201 Sixteenth Street, N.W.
Washington 6, D.C.

California Fruit Growers' Exchange
Sunkist Bldg.
Los Angeles 55, California.

Canadian Kodak Co. Ltd.
Toronto 9, Ontario.

Canadian National Institute for the Blind
186 Beverley Street
Toronto 2B, Ontario.

Canadian Red Cross Society
95 Wellesley Street
Toronto 5, Ontario.

Canadian Tuberculosis Association
304 Plaza Building
Ottawa, Ontario.

Child Study Association of America
221 East 57th Street
New York 19, N.Y.

Child Welfare Information Service
930 F Street, N.W.
Washington 4, D.C.

Consumer Section
Dominion Department of Agriculture
Ottawa, Ontario.

Department of Educational Nursing
Community Service Society
105 East 22nd Street
New York 10, N.Y.

Evaporated Milk Association
307 North Michigan Avenue
Chicago 1, Illinois.

Food Distribution Administration
Nutrition and Food Conservation Branch
Washington 25, D.C.

John Hancock Mutual Life Insurance Company
Boston, Massachusetts.

Massachusetts Society for Mental Hygiene
3 Joy Street
Boston 8, Massachusetts.

Metropolitan Life Insurance Company
Ottawa, Ontario.

National Committee for Mental Hygiene, Inc.
1790 Broadway, Room 916
New York 19, N.Y.

National Dairy Council
111 North Canal Street
Chicago 6, Illinois.

National Dairy Council of Canada,
Suite 305, Journal Bldg.
Ottawa, Ontario.

National Dental Hygiene Association
Shoreham Building
Washington 5, D.C.

National Education Association of the U.S.A.
1201-16th Street, N.W.
Washington 6, D.C.

National Health Council, Inc.
1790 Broadway
New York 19, N.Y.

National League of Nursing Education
1790 Broadway
New York 19, N.Y.

National Organization for Public Health Nursing
1790 Broadway
New York 19, N.Y.

National Society for the Prevention of Blindness
1790 Broadway
New York 19, N.Y.

National Tuberculosis Association
1790 Broadway
New York 19, N.Y.

New Tools for Learning
280 Madison Avenue
New York 16, N.Y.

Play Schools Association
119 West 57th Street
New York 19, N.Y.

Society for Visual Education, Inc.
100 East Ohio Street
Chicago 11, Illinois.

St. John Ambulance Association
St. John House, 321 Chapel Street
Ottawa, Ontario.

Superintendent of Documents
United States Printing Office
Washington, D.C.

The Association for Family Living
209 South State Street, Suite 1426
Chicago 4, Illinois.

The Cleveland Health Museum
8811 Euclid Avenue
Cleveland 6, Ohio.

United States Department of Agriculture
Bureau of Human Nutrition and Home Economics
Washington 25, D.C.

United States Department of Labor
Children's Bureau
Washington 25, D.C.

United States Office of Education
Federal Security Agency
Washington 25, D.C.

United States Public Health Service
Federal Security Agency
Washington 25, D.C.

White House Conference on Children in a Democracy
National Citizens Committee
Children's Bureau, Department of Labor
Washington 25, D.C.

AUX INFIRMIÈRES CANADIENNES-FRANÇAISES

La Naissance d'une Loi

ROGER OUIMET, C.R.

CET ARTICLE n'est pas destiné uniquement aux spécialistes en obstétrique! En vérité, il pourra sans doute leur suggérer des comparaisons et même leur rappeler des souvenirs d'ordre professionnel. Mais comme il s'agit d'une naissance purement juridique, dans une salle de délibérations publiques, elles voudront bien me pardonner de ne pas pousser trop loin l'allégorie!

Une loi voit le jour un peu comme les humains: après plusieurs mois de gestation, souvent pénibles, surviennent les petites douleurs, puis les grandes, puis enfin l'arrivée dans ce monde d'un nouveau-né parfois bien retouché grâce à la collaboration de quatre-vingt-dix praticiens, dont le travail doit recevoir l'approbation de vingt-quatre doctes professeurs de la Faculté, sanctionné par le Recteur de l'Institution qui, lui, baptise l'enfant sans délai.

Celles qui ont lu le court résumé de la nouvelle "loi des Infirmières de Québec," dans le numéro du mois d'août de *The Canadian Nurse* ne peuvent pas toutes connaître les péripéties mouvementées de cette législation révolutionnaire. Disons bien: révolutionnaire, car il n'est sans doute pas d'endroit au monde où se soit manifesté un progrès aussi radical dans le domaine de la reconnaissance juridique et du contrôle de la profession d'infirmière que dans la province de Québec.

Ce n'est certes pas un mince sujet de fierté pour celles et ceux qui ont participé à cette grande oeuvre que d'en constater enfin la réalisation. Raconter les journées et les soirées consacrées à la rédaction, la correction, l'explication, la discussion de cette loi serait tout simplement impossible dans un cadre aussi restreint. D'autres pourront en faire le récit, plus tard et sans doute plus objectivement que ceux qui y participèrent de très près, comme l'auteur de ces lignes. Mais il y a lieu de soulever un coin du voile et de rappeler certaines scènes du drame, au moins pour tâcher de faire mieux comprendre aux infirmières de la province de Québec toute l'importance du changement qui s'opèrera dans leur état professionnel le 31 décembre 1946.

En 1943, l'Association des gardes-malades enregistrées m'avait confié la tâche d'étudier la loi qui la régissait. Depuis vingt ans, aucune modification n'avait été apportée à la Charte de l'Association. Or, grâce au merveilleux essort qu'avait pris l'état de garde-malade ou d'infirmière dans la province de Québec, et au Canada; grâce aussi à la modernisation de tous les services d'hospitalisation, et d'hygiène publique, les exigences de l'Association dépassait déjà de beaucoup celles de sa propre loi au point de vue scolarité, nombre d'années d'études, programmes à suivre, diplômes à obtenir et le reste. Une loi non écrite avait virtuellement remplacé en partie celle qui se trouvait dans nos Statuts.

Il fallait absolument remédier à cet état de choses, et *légaliser* les barêmes déjà reconnus presque partout, afin d'éviter que la demande, de plus en plus effrénée, ne vienne provoquer le retour aux anciennes normes—les seules qui pussent alors être sanctionnées—et aussi afin de pouvoir continuer à obtenir la réciprocité de traitement déjà en vigueur entre les Associations des autres provinces, des pays amis et l'Association du Québec. De nos jours, une loi vieille de vingt ans peut être une très vieille loi! Il fallait donc faire subir à la Charte de l'Association une cure de rajeunissement qui ne risquât pas de l'anémir, ni surtout de l'occire.

L'évolution de fait n'était cependant pas encore assez complète à cette époque pour que l'on pût songer à des innovations trop radicales, ni surtout à l'élaboration d'une loi absolument nouvelle. Par conséquent nous avons fait tout d'abord un travail de replâtrage. Tous les articles de la loi existante, moins deux, furent modifiés pour administrer à la Charte le stimulant, le tonique dont elle avait besoin.

Comme il arrive presque toujours dans ces circonstances, une vague opposition se manifesta devant le Comité des Bills Privés. Les tenants du "Statu quo," les intérêts privés . . . les ambitions déçues . . . les préjugés . . . les soupçons de ceux qui n'ont pas lu le brouillon et sont toujours portés à voir partout l'intervention sinistre de la Main-Noire ou de je ne sais quelle conjugaison de forces ténébreuses, tous ces éléments se liguèrent pour tâcher d'obtenir la remise à six mois, c'est-à-dire, la mort du Bill. Heureusement, après quelques rencontres et quelques discussions, l'accord fut réussi, les "droits acquis"—comme on les appelle assez fréquemment dans les milieux législatifs—furent sauvegardés encore plus explicitement pour contenter tout le monde, et finalement gouvernement et opposition adoptèrent à l'unanimité la loi le 23 juin 1943. Pendant sa courte vie, (qui se terminera le 31 décembre de cette année), cette loi est coiffée de la désignation pompeuse de "7 George VI, chapitre 69." Ouvrons une parenthèse à l'intention de celles qui ne saisiraient pas le sens de ces mots et de ces chiffres. Au Canada, tout comme dans les provinces, et généralement dans le Commonwealth des Nations britanniques, les lois prennent rang selon l'année de leur sanction par le souverain régnant ou son représentant. Sont elles sanctionnées au cour d'une session qui s'est terminée pendant la première année du règne du Roi Georges VI elles sont alors désignées comme la loi "I George VI, tel chapitre du recueil des lois, que l'on appelle chez nous "Statuts." La loi organique de l'Association modifiant la précédente a donc été adoptée et sanctionnée pendant la septième année du règne de notre Roi actuel, soit en 1943 et on la trouve au soixante-neuvième chapitre du Statut.

Nous avons mentionné l'Assemblée législative, le Comité des Bills Privés, les Statuts. Etudions donc le mécanisme par lequel une disposition législative de l'ordre de la Loi des Infirmières doit passer avant de recevoir l'approbation définitive du législateur.

La seule autorité législative dans notre province consiste en deux chambres, dont l'une, l'Assemblée, est élective et l'autre, le Conseil, est formée de membres à vie, lesquelles doivent selon toutes les rigueurs du droit constitutionnel, soumettre pour fins de sanction, au lieutenant gouverneur, représentant l'autorité Suprême, tous les projets de loi qu'elles ont étudiés et adoptés.

Un projet de loi porte le nom de "Bill." Il est des bills publics, qui intéressent la collectivité en général, et des bills *privés* qui sont de la nature du Bill 125 intitulé "Loi concernant l'Association des Infirmières de la province de Québec." En effet, un projet de loi qui n'intéresse qu'un corps public, une personne, un groupe de personnes, une profession est généralement reconnu comme bill *privé*. Cela ne veut pas nécessairement dire qu'il sera soumis au Comité chargé d'étudier les bills privés et d'en faire rapport à la Chambre. Car si le

Conseil des ministres . . . ou parfois même le premier ministre . . . comme cela est déjà arrivé . . . décident que des intérêts publics entrent en jeu, le bill sera alors orienté du côté du "grand comité" ou Comité des bills publics. Font partie de ce comité presque tous les ministres et un nombre imposant de députés.

La loi 7 George VI n'avait subi que le feu du "petit" comité. Rappelons qu'en somme, elle ne faisait que moderniser la charge d'une association *privée* n'ayant aucun pouvoir de réglementer l'exercice d'un art, métier ou profession en dehors de ses cadres.

Le Bill 125 offrait nettement un caractère à la fois public et privé. Son adoption signifiait en définitive la création d'une profession fermée à toutes les personnes incapables de répondre à ses exigences. En effet jusqu'au 31 décembre 1946, n'importe qui peut se présenter comme garde-malade, infirmière, infirmière diplômée, garde-malade "graduée," "practical nurse," ou s'affubler de tout autre titre du genre. Seuls les membres de l'Association privée qui se dénomme "L'Association des gardes-malades *enregistrées* de la province de Québec" ont droit au titre de "Garde-malade enregistrée" ou de "Registered nurse." Dès le 31 décembre 1946, *personne* ne pourra plus commencer à étudier ni exercer l'art ou la profession d'infirmière (c'est-à-dire pratiquer le "nursing") à moins d'être membre de l'Association des Infirmières de la Province de Québec et d'avoir reçu de sa part une "licence" à cet effet. Comme on le voit, la portée de la nouvelle loi est assez considérable pour que l'on s'arrête à en étudier la genèse.

C'est vers le 11 décembre 1944 que le Comité de Régie de l'Association décida de prendre les moyens voulus pour faire reconnaître et fermer la profession dans Québec. Mais, vu les changements politiques qui venaient alors de s'opérer au parlement provincial, il fut décidé de l'avis même de personnages éminents, de différer les démarches jusqu'à une prochaine session de la législature.

Le 29 mai suivant, lors de son assemblée générale à l'Hôtel Windsor, l'Association ratifiait l'attitude adoptée par le Comité de Régie, et confiait la tâche de préparer les "voies et moyens" à votre humble serviteur.

Un Bill Privée de cette envergure et de cette portée ne se présente pas à la légère . . . sauf si l'on désire qu'il soit mort-né. Il faut tâter l'opinion du chef du gouvernement, lequel, s'il le veut, peut expédier sommairement dans les limbes tout projet qui ne lui aura pas été soumis ou qui ne rencontrera pas ses vues. Il faut aussi savoir quelle pourra être l'attitude de ceux de ses ministres et aussi de ses députés que la question peut intéresser. Or qui n'est pas intéressé, de près ou de loin, aux hôpitaux, aux médecins et aux infirmières? De plus, il faut sonder sérieusement l'opposition qui peut faire une obstruction désastreuse.

Heureusement, le premier ministre . . . tout comme le chef de l'opposition . . . était favorable à l'idée de la reconnaissance juridique de cette profession dont il savait la primordiale nécessité et l'excellence.

La chose pressait assez: dès la fin des hostilités en Europe, le marché du travail se voyait déjà inondé de candidates à l'exercice du "nursing" plutôt dénuées de compétence en la matière. De plus une concurrence vraiment déloyale menaçait toutes les "infirmières."

Une fois rassurés sur les sentiments des dirigeants de l'heure, il fallut procéder en vitesse. La session s'annonçait dans quelques jours. Les avis aux journaux, contenant obligatoirement la substance du bill, devaient paraître pendant quatre semaines consécutives dans *La Presse* et *The Star*. Le texte du bill, préparé entièrement par nous et comportant un nombre imposant d'articles dut donc partir par poste aérienne, avec timbre de livraison exprès le 21 janvier 1946, afin d'arriver au plus tard le 22, dernier jour de délai accordé aux intéressés. Entre temps, un parrain (celui qui devait présenter le bill à la chambre basse) avait été choisi, mais qui devait être remplacé à la dernière minute par un médecin:

le bon docteur Gatien, député de Maisonneuve. Au conseil législatif, l'honorable Charles Delagrave, fidèle à l'amitié qui l'unissait au père de l'avocat de l'Association, consentit à introduire la requête ou pétition de l'association devant cette auguste assemblée. Car tout bill privé doit être précédé en Chambre d'une "pétition introductive" qui expose les motifs ayant amené la présentation de la loi. Sous peine d'amende (mais pas d'emprisonnement) cette pétition est soumise elle aussi à des délais de rigueur. L'opposition que l'on nous fit causa d'ailleurs un retard involontaire aux parrains, au coût de $50.00 pour l'Association! Que de paperasse direz-vous! Mais peut-on censurer la prudence du législateur? Toutes les formalités étant accomplies, il fallut alors attendre son tour. Attente providentielle! Car depuis la publication des avis, des journalistes, alertés sans doute par des ennemis du Bill consacrèrent des premier-Québec et des premier-Montréal scandalisés à l'humble et innofensive prose de l'auteur de la loi. On avait conçu en certains milieux le projet nouveau et certes plutôt original . . . de créer au moins deux professions distinctes chez les infirmières: la profession catholique et la profession protestante!

Le Bill ne tenait évidemment pas compte des questions de langue ni de religion puisque entre autre chose, ces droits primordiaux sont sauvegardés et garantis par les traités et la constitution mais ces messieurs des officines journalistiques précitées s'empressèrent de crier au scandale et d'indiquer au législateur la seule attitude "catholique" à leur avis celle du refus énergique d'adopter la loi!

Leurs objugations, leurs menaces mêmes devaient se heurter à des obstacles imprévus: le bill, qui selon eux ne devait pas pouvoir trouver de parrain en découvrit un. Il fut donc imprimé et distribué aux députés de l'Assemblée.

Nouvel assaut: condamnation sommaire du bill, nouvelles prophéties; on en a toléré l'impression, mais il sera promptement exécuté et aura un enterrement de première classe.

Ce diable de projet, sérieusement atteint dans ses oeuvres vives, ne pouvait alors plus compter que sur les soins dévoués des infirmières les plus compétentes et les plus dévouées de la province.

Et nous partîmes en campagne! Ce fut Québec d'abord, il fallut répondre aux questions très au point, toujours très intéressantes, des directrices d'écoles de ce district. Puis naturellement suivit une assemblée aux Trois-Rivières, où nous attendaient de "petits papiers" habilement préparés par quelqu'un qui n'était pourtant pas membre de l'Association! Enfin, les deux districts de la région de Montréal, dont l'un s'était subdivisé pour la circonstance, en groupe religieux et groupe laïc, nous donnèrent l'occasion de faire force discours enflammés et sincères. Journées inoubliables, soirées regorgeant d'intérêt, débats piquants, bref un véritable roman. Croit-on avoir eu raison des objections qu'il en surgit de nouvelles. Il est facile de voir qu'en certains milieux, les concessions sont inutiles: c'est un peu comme à la conférence de Paris, par anticipation; il n'est pas de pire sourd. Toutefois à la suite d'un renversement subit des attitudes oppositionnistes à la dernière minute, la première séance du Comité des Bills publics, se termina sans encombre sur une note d'optimisme. Le procureur de l'Association, aidé de son correspondant de Québec, Me Jean Robert Beaudoin, et de son conseil, Me W. B. Scott, de Montréal (représentant l'élément de langue anglaise et non catholique) furent à leur tour appuyés par les représentants de l'Hôtel-Dieu de Montréal, Me Jean St-Germain, et de St-Mary's Hospital, Me John O'Brien. Les préliminaires terminés, l'étude du bill fut renvoyée du 2 avril au 9 du même mois.

C'est alors que survint l'explosion d'une petite bombe atomique. L'accord paraissait conclu, et qu'il ne s'agissait plus (dans l'esprit des avocats, du moins) que de discuter des modalités de certains changements de détail à rédiger. Mais ne voila-t-il pas que le 4 avril, la Présidente de l'Association, qui avait travaillé inlassablement, jour et nuit, c'est le cas de le dire, à faire triompher le bon sens et la justice, apprit qu'on lui retirait en haut lieu un puissant appui sur lequel nous comptions. Apparemment les choses avaient trop bien tourné à Québec, et certains personnages qui avaient escompté pour nous un échec facile, avaient été cruellement déçus. Il leur avait donc fallu faire volte-face (c'est tout à fait selon les règles de la diplomatie la plus moderne) et cette fois s'opposer au grand jour à l'union et à l'entente. Inutile d'ajouter que toutes les infirmières laïques du district de Montréal et la majorité de celles des autres districts étaient d'accord pour que le bill soit adopté sans créer une division d'ordre confessionnel! Elles savaient que la maladie ne connait pas de frontières; que les traitements ne sont ni catholiques ni protestants, que l'humanité qui souffre fût-elle bouddhiste, marxiste, mahométane, juive, protestante, ou catholique doit être placée sur un pied d'égalité absolue pour le médecin et l'infirmière. Elles savaient aussi que toutes les autres professions au pays comme dans la province comptaient dans leurs rangs des membres de diverses sectes, religions ou croyances. Pourquoi régresser ou rétrograder? Pourquoi leur imposer à elles, anges tutélaires, une distinction qui répugnait à leur conscience professionnelle?

Il fallut donc faire face avec courage à ce nouvel assaut, qui avait cette fois du moins l'avantage d'être visible . . . et palpable . . .

Et la séance historique du 9 avril eut lieu. Décrire l'atmosphère chargée d'électricité de la salle remplie à craquer; l'élan spontané des représentantes de seize écoles d'infirmières venues en délégation de Montréal avec leur procureur, Me Philippe Lamarre, pour appuyer le Bill, la discussion rapide des propositions soumises, les discours des ministres puis des députés de l'opposition; la lecture d'extraits copieux de la brochure du T.R.P. Gaudreault, provincial des Dominicains sur la "Neutralité et la Confessionnalité" . . . la solution lumineuse, suprêmement habile, proposée par le ministre de la Santé, après entente avec le premier-ministre serait impossible à quelqu'un qui a vécu avec angoisse les instants inoubliables de ces quatre-vingt minutes qui devait avoir raison de l'obscurantisme, des préjugés, des sombres projets de discorde et de désunion.

Il y eut bien un assaut timide renouvelé avant la séance du Conseil législatif . . . laquelle d'ailleurs présenta elle-même quelques surprises aux plus aguerris. Mais la partie était gagnée. L'enfant était né viable, et prenait des forces de jour en jour. Les doctes professeurs, en l'espèce messieurs les conseillers, voulurent s'assurer de son avenir; ils le soumirent donc à la question préalable, pour finir par l'accueillir à bras ouverts sans discussion, ni autres modifications que celles qui leur étaient proposées par nous.

C'était une victoire sur toute la ligne pour les tenants de la constitution du bon sens, de l'étiquette professionnelle et de l'entente cordiale, de l'harmonie au sein d'une admirable profession. La nouvelle loi depuis le 17 avril 1946 porte le nom de "Loi des Infirmières de Québec, (10 George VI, chapitre 88)."

La profession d'infirmière, qui n'avait aucune existence juridique au Canada, a donc vu le jour dans la bonne vieille province de Québec. C'est la première profession au pays, et même en Amérique, qui légalement ne peut compter que *des femmes* dans ses rangs. C'est la seule aussi croyons-nous dont les membres se recrutent à la fois parmi les religieuses et les laïques.

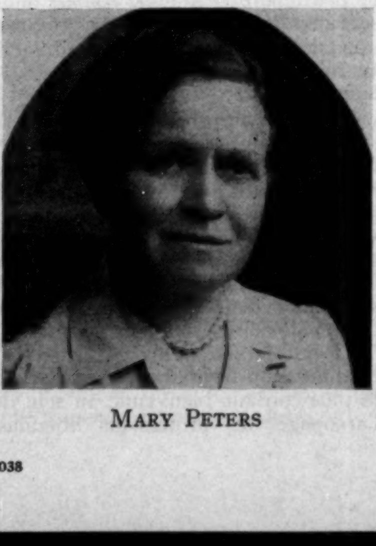
Tout ami du progrès ne peut que se réjouir en apprenant cette nouvelle. Le public profitera énormément de la réglementation d'une profession dont il est en droit d'attendre des merveilles, s'il se fie à l'histoire de son ascension météorique dans le domaine de la science appliquée. Et l'infirmière sera enfin placée au niveau qui lui convenait depuis longtemps.

Ce que femme veut, Dieu le veut! Souhaitons à la nouvelle Association, la plus cordiale bienvenue au sein de l'aréopage des professions libérales.

Interesting People

Gladys Josephine Sharpe is the first director of nursing education at McMaster University, Hamilton, Ont. Born in Toronto, Miss Sharpe received her preliminary education there and entered the Toronto Western Hospital as a student nurse. Following her graduation in 1925, she was awarded the Dr. H. Beatty Scholarship for post-graduate study and proceeded to secure this at the McGill School for Graduate Nurses. Equipped with her certificate in teaching and supervision in schools of nursing, Miss Sharpe returned to Toronto Western Hospital in 1927 as instructor in science. In 1935, she received one of the first awards of the Florence Nightingale Memorial scholarships presented by the Canadian Nurses' Association and enrolled at Bedford College, University of London, where she received her certificate in administration in schools of nursing. Returning to Canada, Miss Sharpe continued her teaching until 1938 when she became assistant principal of the school for nurses of Toronto Western Hospital for two years.

War service beckoned to Miss Sharpe and in 1940 she became matron of the Toronto Military Hospital with the R.C.A.M.C. When the call for volunteers to serve in South Africa was received, Miss Sharpe became senior matron and liaison officer for the Canadian nurses in the South African Military Nursing Service, serving in this capacity until 1943. She was made a member of the Royal Red Cross in recognition of her service in this field.



Mary Peters

Returning to Canada in 1943, Miss Sharpe succeeded to the principalship of the school for nurses at Toronto Western Hospital, relinquishing this position in 1945 to obtain further preparation at Columbia University where she has completed her work for her Bachelor of Science degree. A sincere student, Miss Sharpe is a member of the Kappa Delta Phi.

Miss Sharpe has always taken an active interest in association enterprises. She served for six years on the Board of Examiners for Ontario; as secretary of the Toronto branch of the Committee on Instruction, later becoming chairman of the national committee; she has been second vice-president of the Registered Nurses Association of Ontario; treasurer and president of the T.W.H. Alumnae Association. For relaxation Miss Sharpe turns to riding and reading. She is a member of the Hamilton Nature Club.

Diminutive **Mary Peters,** of Fredericton, N.B., who graduated from the Toronto General Hospital in 1917, who went to Honan, China, that same year with the Church of England missions, and who remained there for twenty-one years as superintendent of nurses, has returned to service. During the period of her retirement from active duty, 1939-46, Miss Peters was never absent from the Red Cross Blood Donors' Clinic unless it was absolutely unavoidable. The busier the clinic, the better she liked it. Numerous times when a critically ill patient could not obtain a private nurse, Miss Peters came to the rescue. Now, because of her superb knowledge of the Chinese dialects, Miss Peters has taken up her tasks anew.

The hospital to which Miss Peters returns was the only one in northern Honan that was not destroyed by the enemy invaders. It functioned all through the occupation in charge of one Chinese doctor. Since the end of the war, a graduate of the Winnipeg General Hospital, Susie Kelsey, has been the only Canadian there.

We salute gallant Mary Peters!

Annie Louise Thomson has been appointed director of nursing and principal of the school of nursing of the Peterborough Civic Hospital, Ont. Born in Scotland, educated in England and at the Normal School in London, Ont., Miss Thomson graduated from the Hamilton General Hospital in 1922. She went soon after to the Lady Minto Hospital, New Liskeard, Ont., where she was superintendent for three years. After serving for two years as assistant superintendent of Queen Victoria Hospital, North Bay, Ont., Miss Thomson returned to Hamilton and engaged in private duty for five years. In 1934, she became obstetrical supervisor at Hamilton General Hospital. Four years later she was appointed night supervisor of Mount Hamilton Hospital, transferring in 1945 to the assistant superintendency. Miss Thomson holds her certificate in hospital administration from the University of Toronto School of Nursing. Stamp collecting, knitting, sewing, and cooking provide for enjoyable leisure hours.

Kathleen Dickson, who organized the nursing division of the Department of Public Health and Welfare in Halifax, has been appointed as supervisor of nurses with the Department of Health, Westmount, P.Q.

Born and educated in Nova Scotia, Miss Dickson is a graduate of Mount Allison Ladies' College. Following her graduation from the Royal Victoria Hospital, Montreal, she enrolled at the McGill School for Graduate Nurses, receiving her certificate in teaching in schools of nursing in 1933. After a brief period as instructor at the Brockville General Hospital, Miss Dickson joined the staff of the Victorian Order of Nurses. She returned to McGill and secured her certificate in public health nursing in 1936. In 1938, she joined the Royal Edward Institute and engaged in tuberculosis work in Montreal.

Miss Dickson was convener of the Public Health Section of the R.N.A.P.Q. for several years. She has also been active in the alumnae association of the McGill School for Graduate Nurses. Handicrafts and music provide her with pleasurable relaxation.

Mary Bourne has been appointed director of nursing at the Oshawa General Hospital where she has been employed since 1940, first as instructor and latterly as assistant superintendent.

Miss Bourne graduated from the Normal School in London, Ont., and taught for eleven years before entering the school of nursing of the Toronto General Hospital. Following her graduation in 1934, she served as relief night supervisor, then assistant supervisor of the neurological ward at T.G.H. until 1940.

D. V. Monk, Hamilton

ANNIE THOMSON

Mary Alberta Hornibrook is now superintendent of nurses at the Mental Hospital, Selkirk, Man. Born in Winnipeg, Miss Hornibrook graduated from the Hospital for Mental Diseases, Brandon, Man., in 1933. After a brief interval, she decided to become a fully qualified nurse and graduated in 1938 from the Montreal General Hospital. During the succeeding years Miss Hornibrook served as superintendent of nurses at Portage La Prairie, Man.; supervisor, Verdun (P.Q.) Protestant Hospital; assistant night supervisor, Montreal General Hospital; and, for

MARY HORNIBROOK

GENEVIEVE SAUNDERS

the past two years, as supervisor in the Allan Memorial Institute, Montreal.

Genevieve Saunders, who served as a nursing sister with the R.C.A.F., is now the superintendent at the Hanover (Ont.) Memorial Hospital. Graduating from the Toronto Western Hospital in 1938, Miss Saunders joined the staff of the General and Marine Hospital at Owen Sound as surgical supervisor. In 1941, she was the recipient of the Dr. H. Beatty Scholarship and qualified in hospital administration at the University of Toronto School of Nursing. She served as night supervisor at Toronto Western Hospital until her enlistment. Golf and music help to while away Miss Saunders' leisure moments.

After twenty years at the Brockville General Hospital, **Edith Moffatt** has retired and is now residing at her home in Renfrew, Ont. A graduate of the Royal Victoria Hospital, Montreal, Miss Moffatt held positions in operating theatres of hospitals in Montreal, Toronto, Winnipeg, and Chicago. She came to the Brockville General Hospital as operating-room supervisor and later succeeded to the position of superintendent of nurses. On the eve of her departure, Miss Moffatt was honored by the Board of Governors, the alumnae association, staff, and student nurses of the hospital.

Completing over forty years of devoted service to the nursing profession, **Isabel McElroy** has retired. Most of Miss McElroy's career has been centred in Ottawa where she was born. She graduated in 1905 from the Ottawa General Hospital and engaged in private duty until she joined the C.A.M.C. in World War I. Upon her return from overseas, she resumed private duty nursing until 1925 when she was appointed night supervisor of the Ottawa General Hospital, a position which she has filled all through these years with great efficiency and kindliness.

The Grey Nuns of the Cross, as an expression of their gratitude and regard, have invited Miss McElroy to make her home in the Ottawa General Hospital as their honored guest. Miss McElroy has accepted this kind invitation. The strenuous demands of her work through the years gave her little opportunity for relaxation. Her many friends join with us in wishing Miss McElroy many happy years in which to enjoy her well-earned leisure.

Margaret Etter, who graduated from the Royal Victoria Hospital, Montreal, in 1916, has retired. Immediately following her graduation, Miss Etter went on the staff of the operating-room at R.V.H. She succeeded to the position of supervisor in 1925 and filled this post with great skill and honor until the time of her retirement. She plans to reside in Montreal.

Burns

First aid for severe or extensive burns should be confined to sedation, treatment for shock, and speedy removal of the patient to hospital. The burn should, of course, first of all be covered with a sterilized dressing. Any attempt at more ambitious treatment must be strongly deprecated, except in cases in which there is likely to be delay in reaching a centre where medical facilities are available. In this event, first aid should include the immediate application of 1 per cent gentian violet or some other similar preparation.

Notes from National Office

An International Atmosphere

THE FIRST TWO WEEKS of September were exceedingly important in nursing history as the Board of Directors of the I.C.N. and the Grand Council of the F.N.I.F. met officially at the Royal College of Nursing in London for the first time since 1939. Canada was fortunate in having three representatives present at these meetings, in the persons of the President, General Secretary, and the Director of the Toronto University School of Nursing.

The following countries were represented at the meeting: Great Britain, United States, Canada, Denmark, Netherlands, India, Belgium, China, Norway, Sweden, Iceland, South Africa, France, Switzerland, Eire, the Philippines, New Zealand, Australia, and Finland.

Plans for the International Congress of Nurses which takes place in Atlantic City, New Jersey, U.S.A., were considered. It has been agreed that the Board of Directors will meet in Washington, May 4-9, 1947, and the Congress will be held in Atlantic City, May 12-16, 1947.

Reports of plans for the various sessions will be dealt with in later issues of *The Canadian Nurse.*

The following are but a few of the interesting comments concerning developments in the various countries as heard by our national representatives during the meeting: Mlle Rousarova, of Czechoslovakia, said that her country now had a nursing division in the Ministry of Health—26 schools of nursing compared with 5-7 before the war—and an education law was in preparation which should place nursing schools on a level with other schools. (A copy of the new education law is being obtained by National Office and will be reported upon at a later date.)

The representative from New Zealand reported a shortage of nurses. The figures caused astonishment. Between 1939-45, the occupied bed rate and the number of student nurses had doubled. There is now one registered nurse to every 2½ student nurses and one nurse to every 1½ patients. The increase of patients was due to the fact that armed services patients were nursed in civilian hospitals. The need for an increased number of nurses was also accentuated by the increase of social problems and by the education authorities demanding more nurses. Private duty nurses are illegal and all such nurses join the staff of hospitals or the Civil Nursing Reserve.

The president of the Nurses Association for the Philippines presented the Philippine flag to the I.C.N. She came to the I.C.N. meeting, she said, for stimulation but her enthusiasm for nursing plans—post-certificate teaching in the Islands, a nursing college at the university, a fund for rebuilding the burned nurses' club—would be difficult to beat.

South African representatives reported enthusiastically on the independence gained for nurses through the passing of the Act, making the South African Nursing Association a Statutory body. Membership by practising nurses and midwives, and to another group by student nurses, is now compulsory. Previously their affairs had been run by medical men. In 1942, when a few nurses sought to find some better machinery than the Trained Nurses Association to improve nursing conditions, the question of trade unions or professional organizations was debated fully at emergency meetings held all over the country, and when voting was taken an obvious mandate was received to forge ahead with the professional organization. The advice of the leading trades union men had been sought and their opinions were that trades unions were not the most suitable organizations for nurses, for not only were nurses unable to strike but many were employed by the Government so were not legally able under the Industrial Conciliation Act to negotiate through trades union mechanism.

The Act is interesting, too, for the fact that there is no discrimination between the Africans and white people.

Britain Leads the Way

The following extract is taken from the news bulletin of the Royal College of Nursing:

> The trained nurses of America, who will be the Congress hostesses next year, are well aware of the formidable cost of visiting the United States, especially for delegates from European countries impoverished by the war, and are doing their utmost to reduce expenses. Other obstacles will be the shortage of steamship reservations and the difficulty of taking sufficient money to the States to meet reasonable needs. Undeterred, however, the various groups which make up the Royal College of Nursing are already planning ways and means and enthusiasm has even spread to the College's Student Nurses' Association, who have asked to send representatives. The admission of nurses in training to this congress of trained nurses would be something of an innovation, but the International Board of Directors, anxious to foster the interest of young nurses in the international aspect of their profession, has accepted the principle of admitting a limited number of student nurses to open meetings as observers. It is interesting to note that this question has been raised by Great Britain, the only country, it is believed, where student nurses are organized on a national basis.

Meetings of the Grand Council, F.N.I.F.

The meetings, held at St. Thomas Hospital, London, on September 11-13, 1946, were chaired by Miss B. G. Alexander, with forty-three delegates representing the I.C.N., the League of Red Cross Societies, and nineteen affiliated F.N.M. committees. The newly-formed committees of Australia, Czechoslovakia, and the United States of America were accepted for membership.

The following elections were made for the coming two-year period: president, Miss Mary Lambie, C.B.E., New Zealand; honorary treasurer, Mr. Duncan A. Stirling, Great Britain; vice-presidents, Miss B. G. Alexander, South Africa; Mrs. Augusta Belmont, U.S.A.; Miss Nan Dorsey, U.S.A.; Mrs. Maynard Carter, Great Britain; Miss Jebb, M.A., Great Britain; Mrs. Marjorie Killby, Great Britain; Miss A. Messolora, Greece; Dame Ellen Musson, Great Britain; Mlle Odier, League of Red Cross Societies; Miss Mary Roberts, U.S.A.; Hon. Sir Arthur Stanley, Great Britain; Miss Effie Taylor, U.S.A.

The Committee of Management consists of the honorary officers, *ex officio*, nominated by the I.C.N., Miss Effie Taylor, Miss Anna Schwarzenberg, and Miss Ellen Broc; nominated by the L.R.C.S., Mlle Hentsch, Mlle Kaeckenbeeck, Monsieur de Rouge; nominated by the N.C.N. G.B., Miss Margaret Smyth, Miss D. M. Dickenson; nominated by the B.R.C.S., Dame Emily Blair, D.B.E., H.H.C., Major General Hawes, G.B.E., D.S.O., M.C.; nominated by Bedford College for Women, Miss Jebb, M.A., principal; nominated by the Royal College of Nursing, Miss Hillyers, O.B.E., president; nominated by the Old Internationals' Association, Mlle Mechelynck.

The Present Program

The Grand Council, having received a report from the Committee of Management on the educational activities of the Foundation, approved these activities and authorized the continuation until the next meeting of the Grand Council. The Grand Council recognized the value of the international courses organized by Bedford College for Women in conjunction with the Royal College of

Nursing and thanked these two educational bodies for the great contribution they have made to work of the Foundation. In view of the fact that the Grand Council has resolved to review its organization and program no decision concerning the revival of these courses was made.

The Grand Council, recognizing the importance of bringing together, as part of the memorial to Florence Nightingale, all documents, writings, and portraits connected with her life and work, also of assembling the same in the library for reference, approved the action of the Committee of Management in requesting the National Florence Nightingale Memorial Committees to prepare a catalogue of all available material of this type.

The Grand Council, having considered the recommendation presented to it by the Board of Directors of the I.C.N., agreed that the F.N.I.F. make a study of its organization, functions, procedure, and program, such study to be conducted with the participation of representatives from the L.R.C.S. and I.C.N. Inasmuch as the International Council of Nurses expects to conduct a similar study of its own organization, the Grand Council agreed that those responsible for these two studies confer jointly before final action is taken by either parent body.

The following report of the Subcommittee of the Grand Council, appointed to consider how a study of the Florence Nightingale International Foundation should be made, was adopted:

That an Advisory Committee be created by the Grand Council to be constituted as a special Committee of the Grand Council, the Committee to be composed of a chairman and six members to include two representatives each from the I.C.N., the L.R.C.S., and N.F.N.M.C.

It shall be the responsibility of this Committee: (1) To act in an advisory capacity to the body set up for the purpose of making the study. (2) To assemble all available material regarding the F.N.I.F. for the information and use of such body. (3) To meet the said body as is deemed necessary. (4) To report the result of the study to the Grand Council. (5) To select a person or persons qualified by training and experience to undertake objective research on all aspects of the F.N.I.F. so that the results obtained will reflect unbiased judgment on past activities and ensure constructive policies for the future. (6) To set up a budget to cover the cost of the work to be undertaken. This budget, after consultation with the president and treasurer of the Foundation, and with their approval, shall be submitted through the treasurer to the members of the Grand Council for their information.

The Advisory Committee shall be charged with the responsibility of securing the necessary funds and shall do so before those who are to be responsible for the conduct of the study are to be employed.

The following were appointed to the Advisory Committee for the study for the F.N.I.F.: (I.C.N.) chairman, D. C. Bridges, Miss Von Hogendrop, V. Snellman. (L.O.R.C.S.) Y. Hentsch, A. Wolf. (National F.N.M. Committees) Ethel Johns, M. Bey Domaas.

Mary Agnes Snively Memorial Lecture

Reprints of this address by Mr. B. K. Sandwell on "Some Recent Shifts in Humanitarian Feelings" are now available and can be secured upon request from National Office, Suite 401, 1411 Crescent St., Montreal 25.

Employer-Employee Relationships

A series of bulletins, prepared by the Committee on Labor Relations and distributed by representatives from the R.N.A.B.C., have been reviewed by National Office. It is felt that the information contained therein would be of interest to other provincial associations and is, therefore, outlined as follows:

The Select Committee on Labor Relations, R.N.A.B.C., consists of three members, one of whom is the registrar.

Its functions: To help nurses solve their own problems; to participate in conference with nurses and their employers and to act, if necessary, as a certified bargaining group.

What is a certified bargaining group? The Federal Labor Law (P.C.1003) states: "The employees of any employer may elect bargaining representatives by a majority vote of the employees affected." This means that the nurses of any nursing staff may elect by majority vote a bargaining group. The R.N.A.B.C. Select Committee on Labor Relations is available for this purpose. A group so elected may apply to the Provincial Department of Labor for certification. The advantage of certification is that in situations where the employer has been unwilling to give consideration to the wishes of the nurses, the employer is legally required to enter into negotiations with the certified group.

How the Select Committee on Labor Relations can help you: Nurses are urged to keep in mind that the Select Committee as a whole or one or more of its members are available to deal with problems before these arrive at the stage where certified bargaining action is necessary. Effective use of the Select Committee in this capacity depends on the extent to which nurses themselves are informed and prepared to co-operate.

How may an individual proceed to help herself?

1. By adopting a businesslike approach in all matters pertaining to the acceptance of a position. This would include: (a) Securing a written statement covering the terms of employment such as type of position and duties, hours of duty and shifts, sick leave, vacation, salary increments, and superannuation. (b) Seeking information as to the policies and objectives of her employing institution or organization. (c) Being informed on the recommendations on personnel practices as drawn up by her association and seeking interpretation, if necessary, as to the application of these recommendations to her specific situation. Copies of these are available at 1014 Vancouver Block, headquarters of the R.N.A.B.C.

2. By being informed as to the chain of responsibilities within the institution or organization in order to refer problems through the proper channels. First approach should be to the person to whom the employee is directly responsible; this should precede referral to a more senior official.

Letter from Cracow, Poland

To the Canadian nurses:

Since five months I received almost every day parcels with food and clothing sent by various Canadian nurses, nurses' associations, and nursing schools for nurses in Cracow. I distribute these gifts among the staff and students of the University School of Nursing in Cracow and among other nurses here.

The gifts are of immense help to us. Most of our nurses fought during the period of German occupation for the freedom of the country. Many of them passed through camps of concentration and prisons. A great number of them lost everything in the war. All that makes them appreciate greatly not only the material value of the received articles, but also the kind thoughtfulness and sympathy of their Canadian colleagues.

Unfortunately, I am not able to thank every sender personally as in many cases it is not possible to read their names and addresses on the parcels. Therefore, I chose this way to thank them all at once and to assure them that we are very grateful for all their gifts.

God bless you all for your kindness.

Signed: Anna Rydel,
Director of The School of
Nursing of the Jagellonian University in
Cracow, Poland.

Notes du Secrétariat de l'A.I.C.

Un évènement de grande importance dans l'histoire du nursing eut lieu au début de septembre; pour la première fois depuis 1939 il y eut réunion à Londres au Collège Royale des Infirmières du bureau de direction du Conseil International des Infirmières.

Le Canada eut l'avantage d'être représenté à ces réunions par trois déléguées: la présidente de l'A.I.C., la secrétaire générale, et la directrice de l'école d'infirmières de l'Université de Toronto. Les pays suivants furent aussi représentés: la Grande-Bretagne, les Etats-

Unis, le Danemark, la Hollande, les Indes, la Belgique, la Chine, la Norvège, la Suède, l'Islande, l'Afrique du Sud, la France, la Suisse, l'Irlande, les Philippines, la Nouvelle-Zélande, l'Australie, et la Finlande.

L'on étudia les plans du Congrès International qui doit avoir lieu l'an prochain à Atlantic City du 12 au 16 mai. Le Bureau de direction se réunira d'abord à Washington du 4 au 9 mai 1947.

Un compte-rendu plus détaillé des assemblées tenues à Londres sera donné plus tard dans *The Canadian Nurse*. Voici tout de même quelques notes en marge des rapports intéressants entendus par une de nos représentantes. Ces notes montrent les progrès accomplis dans divers pays:

La Tchécoslovaquie: Au ministère de la Santé il y a maintenant une division des infirmières. Le nombre des écoles d'infirmières qui n'étaient que de 5 ou 7 avant la guerre est maintenant de 26. Il y a un projet de loi pour mettre les écoles d'infirmières au même rang que les autres écoles du département de l'Instruction publique. (Une copie de cette nouvelle loi est parvenue au secrétariat national; un rapport en sera fait après étude.)

La Nouvelle-Zélande: On rapporte que l'on manque d'infirmières. Les statistiques sont étonnantes: le nombre de patients et d'élèves infirmières a doublé depuis 1939-45. Il y a maintenant une infirmière enregistrée pour 2½ étudiantes et une infirmière pour chaque 1½ patient. L'augmentation du nombre de malades hospitalisés est due au fait que l'on a admis les militaires dans les hôpitaux civils. A cause de nouveaux problèmes sociaux et de l'éducation à faire, on demande encore plus d'infirmières. Il est illégal de faire du service privé et toutes les infirmières autres que les hygiénistes doivent ou faire partie du personnel des hôpitaux ou de la réserve des infirmières civiles.

Les Philippines: La présidente de l'Association nationale présenta le drapeau des Philippines au C.I.I. "J'assiste à la réunion," dit-elle, "dans le but de recevoir des encouragements," mais les projets d'avenir de l'A.G.M.E. des Philippines, tel que l'enseignement supérieur, un collège d'infirmières affilié à l'Université, une campagne de souscription pour reconstruire le club des Infirmières, témoignent bien de son intérêt envers la profession.

L'Union Sud-Africaine: Les représentantes de ce pays étaient enthousiasmées des récents succès remportés par les infirmières: un acte du parlement vient de constituer l'Association des Infirmières en corporation légale. Toutes les personnes soignant les malades doivent en faire partie. Un groupe comprend les infirmières, les sages-femmes, les auxiliaires (practical nurse), un autre groupe les élèves infirmières. En 1942, lorsque quelques infirmières cherchèrent un moyen plus efficace que ceux dont disposait l'Association des G.M.E. de l'Union Sud-Africaine pour améliorer les conditions de la profession, les syndicats ouvriers (trades unions) et les organisations professionnelles furent discutés dans tous les coins du pays, et lorsque le vote fut pris les infirmières optèrent pour une organisation professionnelle. L'on avait demandé au préalable l'avis des chefs des unions ouvrières. Leurs opinions furent que les syndicats ne convenaient pas aux infirmières, non seulement parce que les infirmières ne peuvent faire la grève mais parce qu'un grand nombre sont employés par le gouvernement et du fait ne sont pas légalement libres de négocier avec les syndicats sous la loi de l'Arbitrage. La loi est remarquable par qu'elle n'établit aucune distinction entre les africains et les blancs.

La Grande-Brétagne se prépare au Congrès International de 1947. Les infirmières americaines qui seront hôtesses lors du congrès de l'an prochain se rendent compte qu'il sera très dispendieux de visiter les Etats-Unis. Le coût sera particulièrement onéreux pour les représentantes des pays Européens si appauvris par la guerre. Nos hôtesses feront tout en leur pouvoir pour réduire les dépenses au minimum. D'autres difficultés se présentent tel le manque d'espace sur les navires, les restrictions sur la conversion de la monnaie nationale en dollars américains. Néanmoins, les différents groupes formant le Collège Royal des Infirmières se préparent. Leur enthousiasme est contagieux et les élèves infirmières affiliées au Collège ont demandé d'envoyer des représentantes. L'admission d'élèves infirmières sera une innovation, mais le Conseil International de leur profession a accepté d'admettre un certain nombre d'élèves infirmières comme observatrices lors des réunions publiques. Il est intéressant que cette demande fut faite par la Grande-Bretagne, le seul pays croyons-nous où il y a une association nationale d'étudiantes.

RAPPORT DE L'ASSEMBLEE DU CONSEIL, F.N.I.F.

Il y a deux noms qui se répèteront souvent dans ce rapport. Pour celles qui ne sont pas au courant un mot d'explication s'impose: la Fondation Internationale F.N.I.F. et le "Florence Nightingale Memorial."

La première est en Grande-Bretagne et a pour but de recevoir des infirmières de tous les pays et conjointement avec le Collège Royal des Infirmières de leur donner les possibilités de suivre des cours.

Le "Florence Nightingale Memorial" existait dans chaque pays faisant partie du Conseil International des Infirmières et avait pour but de fournir des capitaux nécessaires pour assurer la permanence de la Fondation et l'admission d'une élève. Plusieurs groupes ayant contribués généreusement se trouvent représentés sur le Grand Conseil, tel que le C.I.I., le Collège Royal des Infirmières, la Croix-Rouge, et des "Florence Nightingale Memorials." A la suite de la guerre une nouvelle organisation s'impose, voilà pourquoi une étude sérieuse de l'institution sera faite.

Les réunions furent présidées par Mlle B. G. Alexander. Etaient présentes 43 déléguées représentant le C.I.I., la Croix-Rouge, dix-neuf affiliées du "Florence Nightingale Memorial." On procéda aux élections du Grand Conseil et les officiers furent élus pour une période de deux ans. Voici le programme proposé au Grand Conseil par le comité exécutif, programme qui fut adopté et dont l'exécution fut autorisé jusqu'à la prochaine réunion du Grand Conseil:

Le Grand Conseil reconnaît la valeur des cours internationaux organisés conjointement par le Bedford College et le Collège Royal des Infirmières, et remercie ces deux organisations pour la part active qu'elles prennent dans la réalisation de l'oeuvre de la Fondation. Du fait que le Grand Conseil a résolu de reviser l'organisation et le programme des cours, aucune décision ne fut prise concernant la reprise des cours.

Le Grand Conseil reconnaît l'importance qu'il a de réunir comme faisant partie du "Florence Nightingale Memorial," tous les documents écrits sur Florence Nightingale et portraits ayant quelques rapports avec sa vie, son oeuvre. Le même travail devra être placé dans la Bibliothèque au profit de ceux qui viendront consulter sur place ces ouvrages. Le Grand Conseil ayant pris en considération la recommandation présentée par le Comité Exécutif du C.I.I. est d'avis que la F.N.I.F. fasse une étude de son organisation, de ses fonctions, ses règlements et de son programme. Que cette étude soit faite avec des représentantes du L.R.C.S. et de C.I.I. Comme le Conseil International se propose de faire une étude semblable de sa propre organisation, le Grand Conseil est d'avis que les deux groupes responsables de ces études se consultent avant de prendre une décision finale.

Le rapport suivant sur les moyens à prendre pour faire une étude de la Fondation Florence Nightingale fut présenté par le sous-comité nommé à cet effet et adopté:

Un comité d'aviseurs doit être nommé par le Grand Conseil. Ce Comité se composerait de deux représentantes du C.I.I., du L.R.C.S. et de F.N.M.C.

Les devoirs de ce comité d'aviseurs seront: (1) D'agir comme aviseur au sous-comité nommé pour entreprendre cette étude. (2) De rassembler tous les matériaux pour cette étude. (3) De rencontrer le sous-comité aussi souvent que nécessaire. (4) Faire rapport au Grand Conseil. (5) De choisir une ou des personnes dûment qualifiées et expérimentées pour faire une étude objective et complète de la F.N.I.F. Les résultats de cette étude devront montrer qu'il y a eu un jugement impartial dans le compte-rendu des activités passées de la Fondation et dans le plan proposé pour l'avenir. (6) De présenter un budget des dépenses que cette étude occasionnera. Ce budget, après consultation avec la présidente et la trésorière de la Fondation, devra être soumis par la trésorière au Grand Conseil. Le comité des aviseurs devra trouver les fonds nécessaires avant d'engager les personnes chargées de cette étude.

RAPPORT ENTRE EMPLOYEURS ET EMPLOYEES

Une série de bulletins, préparés par le le comité des Relations Ouvrières de l'association des G.M.E. de la Colombie-Britannique, a été étudié par le secrétariat national. Voici quelques informations qui peuvent intéresser les associations provinciales:

Le comité des Relations Ouvrières des G.M.E.C.B. se compose de trois membres dont l'un est la régistraire. Les fonctions de ce comité sont: d'aider les infirmières à resoudre leurs problèmes, de prendre part aux conférences entre les infirmières et leurs employeurs et si nécessaire d'agir comme agent négociateur.

Qu'entend-on par agent négociateur? La loi fédérale du Travail (P.C. 1003) dit: "Les employées de tout employeur ont le droit d'élire des agents négociateurs représentant les employées." Cela veut dire que les infirmières au personnel d'infirmières peuvent élire par majorité de voix des représentants comme agent négociateur. Le comité des Relations Ouvrières de la C.-B. est à la disposition de ses infirmières. Un groupe ainsi choisi doit obtenir du Gouvernement provincial, au Ministère du Travail, un certificat spécifiant les employées à l'égard duquel il a qualité de représentant. L'avantage de ce certificat est que si la situation se présentait où l'employeur refuserait de considérer les demandes des infirmières il serait légalement obligé de négocier avec le groupe certifié.

Comment le comité des Relations Ouvrières peut-il nous aider? Les infirmières sont priées de se rappeler que le comité ou l'un de ses membres est à leur disposition pour s'occuper de leurs problèmes avant qu'il soit nécessaire d'intervenir comme agent négociateur. Le comité sera plus ou moins utile selon que les infirmières seront informées et préparées à co-opérer.

Comme chaque infirmière, comme individu, peut-elle aider les autres et elle-même?

1. Considérer une position sur une base d'affaire avant de l'accepter. Ce qui veut dire: (a) demander que l'on la donne par écrit tous les renseignements concernant la position tel que le genre de position, les devoirs qu'en incombent, la durée et les heures de travail, les congées en maladie, les vacances, les augmentations de salaire, et la pension de retraite; (b) connaître, prendre des informations si nécessaire, la ligne de conduite et les buts de l'institution ou organisation dont elle sera l'employée; (c) être au courant des recommandations faites par son association à ce sujet et de leur interprétation dans un cas particulier.

Vous pouvez vous procurer ces bulletins à 1014 Vancouver Block, au bureau de l'A.G.M.E.C.B.

2. En étant au courant de la hiérarchie de la responsabilité dans l'institution ou organisation et référer tous les problèmes à l'intéressée. La personne directement responsable de l'employée doit être vue la première et ensuite une personne supérieure en autorité.

La Conference en Memoire de Mary Agnes Snively

"Quelques changements dans les sentiments humanitaires," par M. B.-K. Sandwell, a été réimprimée; on peut se la procurer en s'adressant au bureau de l'A.I.C., 1411 rue Crescent, Montréal 25.

Lettre de Pologne

Aux infirmières canadiennes:

Depuis environ cinq mois, je reçois tous les jours des colis contenant des aliments et des vêtements, colis envoyés par des infirmières canadiennes, des associations d'infirmières, des écoles d'infirmières, pour les infirmières de Cracovie. Je distribue ces colis aux élèves de l'Ecole des Infirmières de l'Université et au personnel et à d'autres infirmières.

Ces dons sont d'un grand secours car un grand nombre ont tout perdu durant la guerre. La sympathie qui leur est montrée par les infirmières canadiennes leur fait encore plus plaisir que les objets reçus. Comme il est impossible de remercier chacune en particulier je m'adresse à votre Association pour remercier chacune et leur dire quelle est notre reconnaissance pour tous ces dons.

—Anna Rydel

Premature Blood Tests for Syphilis

In view of the seriousness of the venereal disease situation in Canada, the Health League of Canada is intensifying its efforts to gain popular support for legislation calling for compulsory premarital blood tests for syphilis. Such legislation already is in effect in Alberta, Saskatchewan, Manitoba, and Prince Edward Island. British Columbia has enacted legislation, but has not yet put it into effect.

In 1945, roundly 15,000 cases of syphilis and 25,000 cases of gonorrhea were reported in Canada by the Dominion Bureau of Statistics. The total represented a 5 per cent increase over the 1944 combined figures, and 100 per cent above the 1940 total. During the first six months of 1946, the reported 21,933 cases of VD represented an 18.31 per cent increase over the corresponding period in 1945.

The Health League is strongly of the opinion that nation-wide compulsory pre-

marital blood testing will do much to cut the threat of the VD menace. Blood testing is one simple, effective medical measure for helping to stop the rapid spread to innocent persons, specifically the marriage partner and the unborn child, of much already existing infection. And, as health authorities claim that only one half of all syphilitics are aware they are infected, due to unrecognizability or absence of outward symptoms, such tests would serve the purpose of making these persons aware of their condition.

Obituaries

Leonne Marguerite Garceau died suddenly on October 14, 1946, at the age of 29 years. Miss Garceau was born at Grand'Mère, P.Q. She was a graduate of St. Joseph's Hospital, Three Rivers, P.Q., and took postgraduate x-ray training at Laurentide Hospital, Grand'Mère. She went to Trail, B.C., in April, 1945, as nurse x-ray technician.

Veronica Katherine Hanley, who graduated from St. Jos ph's Hospital, Toronto, in 1929, died recently following a serious illness. Miss Hanley had been in indifferent health for the past fourteen years and in consequence had been unable to follow her chosen profession.

Hazel Edna Ulph was killed in a motor accident in Saskatchewan on October 11, 1946. Miss Ulph graduated in 1945 from the Moose Jaw Providence Hospital. After graduation she remained on the staff until July 1, 1946, when she accepted the position of matron at the Community Hospital, Kincaid, Sask., which position she held at the time of her death. At the funeral service, the Providence Hospital choral group sang the hymns with Miss Jean Graham, student nurse, as soloist. The funeral cortege passed through the line of uniformed nurses, eight graduate staff nurses acting as a Guard of Honor.

Mrs. Ada Louise (Barlow) Newcombe died recently in Wales. Graduating from the Hamilton General Hospital in 1939, Mrs. Newcombe went overseas in 1942.

Helen Sirrs, A.R.R.C., assistant matron at Sunnybrook (D.V.A.) Hospital, Toronto, died recently in Christie St. Hospital after an illness of only five days.

Previews

Many nurses, without much previous business experience, find themselves called upon to assume responsibility for the purchasing of supplies for every department of the hospital. How to fulfil this task most efficiently is an ever-pressing worry to the inexperienced. In order to give some worthwhile assistance, we are glad to present next month a valuable contribution on this topic by **Hilda M. Bartsch** who has been in charge of the buying for the Victoria Public Hospital in Fredericton along with her numerous other duties as superintendent.

From a wide variety of sources, the student nurse assembles information regarding the astounding advances which have been made in medical science in the past century. **Dr. A. Gaum** has concentrated a large number of these bits of factual information into an interesting description which you will be able to read next month.

Greater understanding of the importance of the Rh factor in the ordinary lives of men and women has increased the need for information of this topic by nurses. To further this end, our feature article next month will be a very clearcut analysis of the various factors by **Dr. R. L. Denton.**

STUDENT NURSES PAGE

Pernicious Anemia

MARGARET ZAHN
Student Nurse
Royal Columbian Hospital, New Westminster, B.C.

MR. JONES'S ADMISSION to hospital, for treatment of an injury to the cervical area of the spine due to a fall, lead to the discovery that he was suffering from an advanced condition of pernicious anemia. His history showed definite indications of this condition. As a steam engineer with a large mining corporation, he did not have a very satisfactory home environment as he slept in a bunkhouse where quarters were crowded and smoky. The food, however, although prepared in large quantities, seemed satisfactory. Approximately one year ago, Mr. Jones began having tingling sensations in his fingers and toes, which in time progressed until the forearms and the lower extremities to the waist were involved. Mr. Jones said that during the last few weeks he had had to stamp his feet very hard to realize he was actually touching the floor. It appeared to him that he was walking on sponges. He also suffered from dizzy spells and nausea. Then, one day he fell.

On admission, his cervical spine was x-rayed for a possible fracture due to his fall. The report returned with no evidence of fracture. The doctor thought he might be suffering from pernicious anemia. His symptoms pointed to it, as his skin was a typical lemon-yellow color; he was very listless and drowsy and complained of dizziness, nausea, indigestion, slight diarrhea, and vague frontal headache.

His blood count report was quite typical with a red blood count of only 2,510,000, hemoglobin of 62 per cent as contrasted to the normal red blood count of 5,000,000 and 100 per cent hemoglobin. The reason for his high hemoglobin in spite of the low red cell count was because, typical of pernicious anemia, his blood showed a marked increase in macrocytes. His white cell count was slightly lower than normal, as is often the case in this disease. The result of a gastric analysis showed an absence of hydrochloric acid in his stomach.

Once the diagnosis of pernicious anemia was established the doctor ordered 1 cc. liver extract to be given daily for five days, then given every three days. We explained to Mr. Jones that this was "replacement therapy" and that as his body lacked this material it would have to be substituted for the rest of his life. Liver extract stimulates the red bone marrow to produce red blood cells. He was given ferrous sulphate, gr. x. t.i.d., to increase the iron in his blood and consequently increase the hemoglobin content. With each meal he was given m.xx of hydrochloric acid to replace that missing in his stomach and thus aid in his digestion.

Mr. Jones also needed supportive nursing care to supplement his medications. His back and pressure points were rubbed with cocoa butter and alcohol alternately to prevent bed sores which might have arisen because of the poor vitality of his skin. The areas of intramuscular injection were well massaged each time to stimulate circulation to the part, and also to disperse the medication throughout his tissues. Care was taken to give the injection in the upper outer quadrant of the buttocks with sterile equipment. His mouth was kept clean with frequent mouth-wash and he soon acquired the habit of regular use of his tooth-brush. We checked his voiding to be on the alert for any sphincter involvement which may occur in an advanced pernicious anemia as a neurological complication. Fortunately, his disease had not yet progressed that far. His diet was simple yet wholesome. After two weeks of bed rest he was allowed out of bed and helped about the ward to stimulate his circulation and to help overcome his apathetic attitude. Fortunately, he did not seem to have the fairly typical irritable manner.

When he was ready to leave the hospital, Mr. Jones had a good idea of his proper diet and the necessity of having his injections of liver extract regularly, once weekly the doctor said. We told him that he should see his doctor about every six months and cautioned him to take care of himself if he caught cold. He felt that he could not go back to his former job, so he is going to seek some lighter form of work as he realizes his condition in no way affects his ability to live a normal life.

Manitoba Student Nurses' Association

Formation of a Manitoba Student Nurses' Association in November, 1944, was an event in the history of nursing in Manitoba. The M.A.R.N., with Frances Waugh heading the committee, sponsored the organization of the association at a meeting attended by representatives of eleven Manitoba training schools.

The purposes in forming the association were, briefly, for official representation of student nurses; to keep students informed of special events in the world of nursing; to broaden the cultural background of students; and to provide a means of friendly contact among students throughout the province. The executive is patterned after that of the M.A.R.N. In addition, committees have been formed to carry out the various purposes of the association, namely, current events, dramatics, music, and sports. Each of these committees arranges two mass meetings during the year and provides interesting entertaining, and informative programs.

Features that have developed since its formation are: the M.S.N.A. pin; sports night each Wednesday at the Y.W.C.A., with approximately two hours of instruction time divided between swimming and gym; the annual banquet.

The executive of 1944-45, with D. Marshall as president, laid the cornerstone of the association with high ideals and great things to accomplish. The 1945-46 executive, with L. McDonald as president, added still further to the growth of the M.S.N.A. by better organization of committees and contact with out-of-town students. Both executives report a broadened outlook resulting from gradual development of inter-school acquaintances through which it is found all student nurses seem to have common problems, interests, and ideals.

Watch Your Step

Cellar, basement, or attic stairs often are dangerous because of inability of users to distinguish the steps or railings in dim light. Painting the edges of the treads and the railings of such stairways white will help prevent accidents which might have serious results.

Leper Work in India

GEORGINA L. AMENT

Editor's Note: The following account grew out of a talk which was given to the Alumnae Association of the Women's College Hospital, Toronto:

I have worked in India for over twenty years, and there are many aspects of life and work in that country about which I might speak out of my own experience. I have chosen a subject which will be of medical interest — leprosy.

For the past ten years of my time in India, I have been superintendent of a Leper Home and Hospital under the auspices of the Mission to Lepers. This Mission has been in operation for over seventy-one years seeking to bring relief to sufferers from the dread disease of leprosy. The Mission originated in Ireland on behalf of lepers in India, but during the years it has grown and expanded its activities until there are offices in all Christian lands and work amongst lepers in seventeen different countries.

Leprosy is a disease of which nurses in western countries have very little practical knowledge, due to the fact that they might go through their training, and have years of practice in the profession, without ever meeting a case of it.

None of you needs to be told that leprosy is one of the oldest diseases known. We can go back thousands of years B.C. and find it recorded in the laws of Moses. Coming nearer to our own time, it is not so many centuries ago that the disease was very prevalent in Europe. In some old churches in England even yet, there are to be found slits in the walls, known as "leper squints", through which lepers could look on while services were being held. About the same time burial services were said for live lepers in England. The present office of the Mission to Lepers in London is only a few hundred yards from the old leper hospital, St. Lazar.

In Canada there are two leper hospitals — one in the east and one in the west. There is also one at Carville, Louisiana, under the American Mission to Lepers, where they have accommodation for about 350 patients.

It was not until about 1871 that the Norwegian scientist, Hansen, isolated the bacillus causing leprosy and thereby provided a medical approach to the disease. Since that time, great strides have been made in the treatment, mostly through the administration of chalmoogra oil, which still ranks first in efficacy in treating leprosy, although much is hoped from some of the more recent drugs, such as penicillin. Chalmoogra oil, as a drug in the treatment of leprosy, was discovered by an Indian many years B.C., but as it was used orally in its crude form few could tolerate it. Research, however, has developed this drug so that it can now be given interdermally, intermuscularly, and intravenously with very encouraging results, provided we can get the patients to come to us soon enough.

The majority of patients show a history in almost every case, if honestly given, of some other case of leprosy in the family. It is not believed by medical authorities that just an occasional contact with a leper will infect another person. Neither is it hereditary. There is nearly always found to be a close contact over a fairly long period.

Leprosy is one of the most difficult diseases of which to get an absolutely accurate history. This is partly due to the fact that it can lie dormant for a long time, sometimes for many years, before the early symptoms appear. Then, too, we find, especially at the time of admission, for some reason or other, patients hesitate to reveal that some other member of the family had been similarly afflicted.

With few exceptions the early cases have every hope of a cure, or becoming what is generally spoken of as "symptom free." When patients come to us with the very early sign — a slightly raised, anesthetic patch — we can almost always assure them of a cure. If they come after deformity has set in, we are able in the majority of cases to "arrest" the disease so that it does not progress further, although we cannot cure the deformity. Then there are the "burnt-out" cases so far as any cure at all is concerned. We can only treat sores and give temporary relief. Although at this stage they are mostly helplessly deformed, many of them blind and helpless, they are non-infectious.

When patients come to us, specific tests are made. A small fleck of skin is snipped from the lobe of the ear, where the organism frequently settles in large numbers. That is examined microscopically. Blood and mucous membrane smears are also made and examined. Bacilli found in any one of these tests make diagnosis certain, even when patches might be doubtful. During the war, army medical men were encouraged to visit leper hospitals. Several such groups with their officers came to us. They were just as concerned that their men should learn not to diagnose a case as leprosy erroneously, as that they should know when it was leprosy.

Treatment, in most cases, begins immediately, and results are most gratifying, especially in the early cases. These are coming in ever-increasing numbers. My first visit to a leper hospital, twenty-three years ago, left me feeling that medically it was all hopeless. This was due to the fact that thirty or forty years ago, out of which period the majority of those patients had come, they had come too late for a cure or of becoming even "arrested cases." Most of them were "burnt-out" cases. Twenty years later there are in that same home nearly 50 per cent of the patients, who to the lay observer would appear quite healthy. In regard to many of these we are frequently asked by visitors if they are really lepers.

During the course of treatment, and no one can tell how long this will take, tests are made and body charts showing affected parts are carefully kept. Six months after the first "negative" test, during which period the patient is removed from danger of re-infection, another test is made. If still negative, a certificate of being "symptom free" is given and that gives the patient entry once more, with danger to no one, into some employment or into his community. In other words he may take up life as a normal citizen.

The "burnt-out" cases become, more or less, permanent charges of the Mission. Most of them are too disfigured and deformed to earn their own living outside the hospital, although many live very useful lives by helping with the work in the hospital in various ways.

There are various types of leprosy such as nerve leprosy, one of the most crippling and painful varieties even though not infectious. Then there is the skin type and the nodular type, both highly infectious, especially the latter where each nodule is teeming with the bacilli.

Another important branch of the work is the saving of the children. As they are never born with the disease, our aim is to get them separated from the parents at the earliest possible date. At one time this was a most difficult task. Parents who came with healthy children would refuse to be admitted themselves rather than be separated from their children. It was very sad to see them go off with the youngsters, only to return in a few years having passed on the infection to the children. Now that they see their children can have the same opportunity as other children if brought up in healthy surroundings, they gladly allow us to place them in the healthy children's home, of which there is one connected with each leper hospital. They are allowed to see them every week and are now quite co-operative. Children born in the hospital are taken from the mother at birth and these remain quite healthy. The younger one is, the easier it is to contract the disease. As one gets to thirty-five and over the immunity to it increases.

That is just a bare outline of leprosy and the medical approach to it. But the treatment of leprosy neither begins nor ends with drugs. Patients must have the most nourishing food available and strenuous exercise, and so the care of gardens by the patients themselves is strongly advocated in our leper homes and hospitals. Also good healthful sport and drill are provided. But the need is even more than medical or physical. There is above all else a spiritual need. To explain this, I can find no better words than those of Rev. A. S. Jones in reference to one of our leper homes in India: "The patient endurance that is seen here is of a different quality from that of the stoics. It is of the quality that bears the unique stamp of the New Testament. It is Christian fortitude and is characterized by a triumphant joyousness. The separation, the pain, the broken hopes, the disfigurement, the longing for home, and wife, or husband and children are all here, but all is suffused by a triumphant happiness, and an atmosphere of life and hope pervades the Home. In these days we can say with all thankfulness that in the treatment there is hope of a cure; patients are being discharged symptom free. It is not in this fact, however, that there lies the secret of this joy, though no doubt it is contributory to it. The real reason is that these people have in disaster found opportunity and have learnt to rejoice in tribulation." Yes, in bringing these people into touch with the world's Redeemer Who said, "I come that they might have life and that they might have it more abundantly," we bring them into touch with one of the greatest factors in the cure of the disease. Nothing but a Divine love and compassion can lift the lives of these stricken people, crushed with disappointment, shame, and despair, and put them in that spiritual attitude where medicine can take effect and perfect the cure.

From our Exchange Journals

India: Maternal mortality is appallingly high, the last reported figure (1936) being 24 per 1,000 live births. This is considered to be due to a large extent to the lack of ante-natal care. Though some clinics have been established by the government, the Indian Red Cross, hospitals and industry, there is not yet any system by which patients who fail to attend regularly can be followed up by home visiting.

A great many women are delivered at home where they have the choice of the following services: (a) a corporation midwife—this service is free but the case load is so heavy that the midwives seldom have an opportunity to see their patients prior to delivery; (b) private midwives—this service is patronized by the well-to-do patients; (c) dais—partially-trained attendants, most of whom are illiterate; (d) relatives.

The high mortality rate is partly due to the extremely low standard of living, gross undernourishment, and disgraceful housing conditions. In these deplorable conditions, domiciliary midwifery is out of the question and efforts are made to persuade patients to go to hospital. Anemia accounts for 24 per cent of the maternal deaths, an exceedingly high figure for this preventable and curable condition.

Ante-natal care is such a new development that it is not accepted by a majority of the women. Wholehearted efforts to educate the people to its value are urged.

Condensed from article by JOAN COURT,
Nursing Journal of India

Australia: Ways and means of developing post-graduate courses for nurses have been considered by the Royal Victorian College of Nursing. It was ascertained that courses could not be brought under the auspices of the University of Melbourne unless the ordinary educational requirements for university courses were observed. Since matriculation standing for training in nursing is not required, some other avenue had to be sought. It has now been found possible to bring the greater part of the courses under the University Extension Board. Lectures and examinations will be conducted by University lecturers with the R.V.C. of N. being responsible for the teaching in certain sections of the courses and acting as a co-ordinating body for the administration and financial arrangements. It was decided to concentrate on three courses—sister tutors, nursing administration, and industrial nursing, and to pattern the curricula after the courses given at the University of London.

UNA—Journal of the
Royal Victorian College of Nursing

Health of Displaced Persons

With some 664,000 displaced persons still under the care of UNRRA officials in the assembly centres in the three western zones of Germany, a survey has been made of the incidence of the communicable diseases in these camps and the effectiveness of the various immunization measures. There has been practically no smallpox, typhus, or relapsing fever. Poliomyelitis has been almost absent and cerebrospinal meningitis rare. Typhoid fever was low and paratyphoid fever practically non-existent. There were only sporadic cases of dysentery and epidemic jaundice.

In spite of intensive immunization, diphtheria has remained a serious problem. The rate has not been so high, however, as among the German civilian population. The immunization campaigns were effective in reducing the case mortality rate. No mortality was reported from scarlet fever, measles, whooping cough, chickenpox, and mumps, although there were numerous cases of each reported.

The incidence of tuberculosis cases discovered was about 2.5 per cent but the mortality was low. Venereal diseases are prevalent, although not to the same extent as in various army groups. The reported incidence, for the past year, is around 1 per cent for syphilis and 2 per cent for gonorrhea.

—*UNRRA Monthly Review*

Hospital Meal Service

A new stainless steel *Mealpack* container, Model 11, for serving hot meals to hospital patients and personnel, is announced by Mealpack Corporation of America, 152 West 42nd Street, New York City 18. Double-seal insulation and patented construction permit packaging individual freshly cooked hot meals at nearby or remote kitchens for delivery and serving up to three hours after packing.

This container allows hot courses to be packed at the peak of their full flavor and nutritional value in specially designed blueplate dishes made of ovenware type glass. Each meal may be sealed with a laminated aluminum foil dish closure lid which minimizes oxidation and loss of nutriment, and preserves natural food colors, aromas, moisture content, and palatability. Spillage and intermingling of food flavors are eliminated.

A secondary seal retains the original packed heat of the meal when the blueplate is enclosed within the container. The container then stores the natural heat until each patient is ready to be served and keeps the meal hot throughout the eating period. No external heat need be applied. Container and dish may be thoroughly cleansed after every use in standard dishwashing equipment.

The *Mealpack* container halves are clamped together with a patented Sealock device. A cardboard disc, inserted in the Sealock, identifies each special diet or standard meal as packed and may designate the patient for whom it has been prepared.

Canned Foods

Canadian housewives, who empty canned foods from metal containers as soon as it is opened, may be surprised to learn that the food is just as wholesome and less liable to contamination if left in the can. The Canadian Department of Agriculture, in a bulletin entitled "Canned Fruits and Vegetables for Variety in Everyday Meals" states: "Canned fruits and vegetables may be safely left in the can after opening." In a more detailed report, the United States Department of Agriculture says:

"It is just as safe to keep canned foods in the can it comes in if the can is cool and covered—as it is to empty the food into another container. Thousands of housewives are firm in the faith that canned foods ought to be emptied as soon as the can is opened, or at least before the remainder of the food goes into the refrigerator—one of the persistent food fallacies.

"Cans and foods are sterilized in the (canning) processing. But the dish into which the food might be emptied is far from sterile. In other words, it may have on it bacteria that cause food spoilage."

Our Alumnae

HELEN L. MACKENZIE

The purposes of the St. Paul's Alumnae Association in Vancouver are: to promote fellowship, unite, and advance the interests of St. Paul's graduates, foster professional progress, and promote the interests of St. Paul's School of Nursing. All graduates of St. Paul's School of Nursing are eligible for membership, and are asked to participate in all the activities—from sports to teas, from rummage sales to the annual dance.

As one will see, our alumnae is alive and active; and always willing to help, not only ourselves, but others. We have three chief funds, namely, the Bursary fund, the Sick Nurses' Benefit fund, and the Emergency fund—towards which the proceeds from our many activities go.

The Bursary fund was started last fall. To begin with, voluntary donations from the nurses and doctors of St. Paul's Hospital were received. This enabled us to send our first recipient of the bursary, Marjorie Brown, to the university in September, 1945, for a course in teaching and supervision. Miss Brown has now successfully completed this course, and has returned to St. Paul's pediatric department as a teacher and supervisor. Since then other means of raising money for the Bursary fund have been adopted. Through the generosity of one of our doctors, a "Bursary Tea" was held at his home last November, proving to be a social success as well as a financial one. The following month the International Kennel Club held an all-breed sanction dog show at the Horticultural Hall, and the proceeds from this were divided between the Bursary fund and the Sick Nurses' fund. At this dog show our nurses raised extra money by the sale of coffee, "hot dogs", and doughnuts. Sums in the Bursary fund have increased and, with an additional donation from the doctors, we shall be able to give two bursaries this year.

Our Sick Nurses' Benefit fund was started in 1938 for the purpose of providing insurance for any member of the association who is disabled by reason of sickness or accident. Proceeds from various activities held throughout the year keep this fund going.

Every year, usually in October, we hold our "Country Fair." Much credit must go to our nurses who work tirelessly throughout the year making aprons, stuffed animals, preserves, knitted wear, household gadgets, etc., to sell at the fair. One need only to attend this bazaar to realize how much work and preparation is done by our members.

Another annual affair is the spring formal dance, held soon after Easter. This is always a gala and festive occasion, adding considerable color and gaiety as well as many more dollars for our charities.

The rummage sale has become still another successful means of raising money for alumnae work. After our last sale, left-over clothing and other useful articles were packed and sent overseas to war-torn countries.

We also answered the appeal for capes and coats for the nurses of Holland. These were collected by our members, and sent on by the Vancouver Chapter of the Registered Nurses' Association.

During the war years we did not forget about those "over there." Knitting of sweaters, socks, helmets, scarves, etc., was done by our girls for the Seamen's Club and an air force squadron. Money and cigarettes were also sent to add to their comforts.

In recent months, contributions of twenty-five dollars were given to the I.O.D.E. Book Fund, the Cancer Fund, the Spastic Paralysis Fund, and the Red Cross Society. During the Cancer Fund drive, several of our nurses responded to the plea of the Women's Voluntary Service and went out canvassing.

Flowers, visits, and appropriate cards go to any of our nurses who are ill in hospital, and special attention is given to nurses who are patients at the sanatorium at Tranquille. To them go special greeting cards at regular intervals, gifts, and a subscription to *Reader's Digest* each year. Flowers are also sent to Sr. Superior and Sr. Columkille on their feast days.

In April of every year, the graduating class is entertained by the alumnae. Sometimes the entertainment is in the form of a dinner, theatre party, or tea, but this year we took the girls on a cruise to Wigwam Inn, returning via Belcarra Park, where refreshments were served.

As a means of bringing together all of our graduate nurses, the alumnae holds a "homecoming" each year, thus enabling nurses and Sisters from the very first class to the last one to get together for a wonderful evening of chatting, "remembering when", singing, and supping. This year we are endeavoring to have our "homecoming" in the form of a banquet at the nurses' home. (During the war a social evening was substituted for the annual banquet.)

We do not forget the graduate nurses on the hospital staff, particularly those away from their home schools. Last December they were entertained at a pre-Christmas party—games, music, contests, and refreshments were enjoyed by all.

Remembering the children, too, is part of our work and so each June we hold a mother and children's garden party, weather permitting, or a tea in the lounge. Sandwiches, cakes, ice cream are served to the children, and tea for the adults. A fish pond is an added attraction for the youngsters, and a grand time is had by both young and old.

Our newest money-raising ventures have been the sale of homemade candy and knitted goods. The delicious candy, which is sold through the registry office, knitted articles, particularly baby garments, bed-jackets, and men's socks are made by our members and friends, and sold at the booth in the hospital sponsored by the Canadian National Institute for the Blind.

Leaving the financial and social side of our work we turn to the educational side. Besides providing bursaries for our graduate nurses we try to provide guest speakers at as many of our alumnae meetings as possible. Members are urged to attend meetings of the Vancouver Chapter, and the annual conventions of the Registered Nurses' Association. This year twelve of our members attended the convention in Victoria.

In September of last year a committee for sports was formed, and a very successful winter of bowling, ice skating, etc., was enjoyed. Soft ball and tennis have been substituted for the summer months.

Our alumnae meetings take place on the second Tuesday of each month, excepting in July and August. After the business part of the meeting has been conducted, a lighter air is assumed, and we have our "dime draw", guest speaker, and refreshments.

To notify our members of approaching meetings, and to relate interesting news about our nurses and their activities, we send out a monthly bulletin. This is cleverly arranged and is eagerly awaited by us all, particularly those members away from home. This paper is sent to all of our graduates, providing, of course, that we have their address.

And so goes the story of our alumnae and its activities. We, here in Vancouver, are anxious to meet and become acquainted with members of other hospital alumnaes across Canada. Won't you come to visit us when you make your trip out West to the land of beautiful sunsets, snowcapped mountains, and blue seas?

Ontario Public Health Nursing Service

The following are the appointments to and resignations from Ontario Public Health Nursing Service:

Appointments: *Mrs. Blanche Gordon* (Toronto Western Hospital and University of Toronto certificate course) as public health nurse with Burlington Board of Health; *Maxine Ward* (B.Sc., University of Western Ontario) to teaching staff, Institute of Public Health, University of Western Ontario; *Mrs. Arlie Laxton* (B.Sc., University of Western Ontario) to Sudbury Board of Health; *Lorraine Larsen* (St. Michael's Hospital, Toronto, and University of Toronto certificate course) as public health nurse with Oakville Board of Health; *Mrs. Nora Cunningham* (St. Luke's Hospital, New York City, and University of Toronto certificate course) as public health nurse with Orillia Board of Health; *Phyllis Shannon* (Toronto Western Hospital and University of Toronto certificate course) to Barrie Board of Education; *Doris Carter* (Royal Victoria Hospital, Montreal, and McGill University certificate course) to public health nursing staff, Ottawa Collegiate Board; *Margaret Goble* (B.A.Sc., University of British Columbia) to United Counties Health Unit nursing staff.

Resignations: *Ida Dunke* (Victoria Hospital, London, and school nursing summer course, Ontario Department of Education)

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and *Veronica Winterholt* (St. Michael's Hospital, Toronto, and school nursing summer course, Ontario Department of Education) have retired from the Kitchener Board of Health.

Pearl Stiver, nursing supervisor with the Division of Veneral Disease Control, Ontario Department of Health, is on leave of absence to pursue post-graduate study at Columbia University.

Book Reviews

Demonstrations of Operative Surgery for Nurses, by Hamilton Bailey, F.R.C.S. 348 pages. Published by E. & S. Livingstone Ltd., Edinburgh. Canadian agents: The Macmillan Co. of Canada Ltd., 70 Bond St., Toronto 2. 1945. Illustrated. Price $6.25.

Reviewed by Mary Warnock, Operating-Room Supervisor, Royal Victoria Hospital, Montreal.

This is a very informative and well-illustrated book. In it the author has achieved his purpose of giving a running commentary of actual operations with excellent illustrations.

The first section of the book deals briefly with operating-room technique. Following this we are given the operative procedures. In this section, the author gives excellent descriptions of various operations, emphasizing and illustrating the important points in each procedure.

The last few chapters explain in detail the examinations done on the body cavities with special instruments.

This book is of great value to both student and graduate nurses because, with an understanding of the principles upon which each operation is based, their work will become more interesting and they themselves more skilful.

Everyday Psychiatry, by John D. Campbell, M.D. 333 pages. Published by J. B. Lippincott Co., Medical Arts Bldg., Montreal 25. 1945. Price $7.50.

Reviewed by Kathleen Marshall, Allan Memorial Institute, Montreal.

This book on psychiatry does not present a table of classifications of mental disorders; general paresis is only briefly referred to, and the senile and arteriosclerosis are not mentioned. The author writes of the borderline type seen so frequently in the general hospital wards and in private practice. Several chapters are devoted to the psychoneuroses and deserve careful reading. Alcoholism and the development of the cycloid and the schizoid personalities are clearly presented. The chapter on the psychopathic personality gives a new viewpoint on this little-known subject.

Dr. Campbell has a unique method of presentation and brings many new ideas in to show the various types of personality formation. He draws on his vast experience in private practice as a general practitioner, in the psychiatric hospital, and in the naval service with the result that the book makes interesting reading. It was written, primarily, for the general practitioner but will be found of interest to social workers, nurses, and others interested in this field.

Together with the more orthodox books on psychiatry, this book will fill a valuable place in the nurse's library. The author suggests that the readers begin the application of the ideas that are put forward in their everyday observation of friends and patients.

The Service Load of a Staff Nurse, in one official public health agency, by Marion Ferguson, Ph.D. 51 pages. Published by Bureau of Publications, Teachers College, Columbia University, 525 West 120th St., New York City 27. 1945. Price (in U.S.A.) $1.85.

Reviewed by Barbara Logan, Victorian Order of Nurses, Montreal.

This study undertakes to determine the service load of the individual staff nurse according to demands for her services—just how many families can she be expected to serve, and for what reasons? It attempts to

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solve the administrative problem of balancing quantity and quality of service against the number of nurse-hours available. Through careful collection of data by the Bureau of Nursing of the District of Columbia Health Department, and a combination of job analysis and time study, a workable formula is determined.

Miss Ferguson presents the problem and its solution in a concise, technical manner. There is a careful definition of terms used, a resume of studies already made in the field of work assignment, and complete tables and analyses of assembled data. The final formula can be adapted and modified according to the needs of a specific agency. It may be applied to the service load of the agency as a whole as well as to that of the individual nurse.

Supervisors and administrators in public health should be interested in this scientific approach to an old problem. Details of problems encountered during the study would serve as a guide to in-service education and the preparation of public health nurses.

The Modern Attack on Tuberculosis, by Henry D. Chadwick, M.D. and Alton S. Pope, M.D. 134 pages. Published by The Commonwealth Fund, 41 East 57th St., New York City 22. Revised Ed. 1946. Price (in U.S.A.) $1.00.

Reviewed by Katharine M. MacLennan and Barbara Smith, Provincial Sanatorium, Charlottetown, P.E.I.

In this edition of "The Modern Attack on Tuberculosis," the authors have made revisions in their book to keep in step with "many recent developments in administrative practice and in the techniques of tuberculosis case-finding and control."

In the chapter on Epidemiological Aspects, the text shows how, through the wide use of mass x-ray examinations, many more cases of the disease are being reported.

Considerably more emphasis has been placed on case-finding methods. Significant information as to age-distribution has been brought out through routine x-ray examination of all military inductees. The problem of cases of rejectees is brought to the reader's attention. Reference is made to the problem of exposure of nurses and medical students in general hospitals and sanatoria.

In the last chapter dealing with a community campaign, additional material on the development of tuberculosis in contacts and a short section on rehabilitation will be found of great value.

THE IMPATIENT PATIENT

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The book has many graphs and statistical tables, most of which, as the authors are Americans, refer to conditions in the United States. Thus the appeal to Canadian students may be somewhat lessened. In a few cases, however, the tables refer to Great Britain and Canada.

This short volume is written in a style which is professional yet simple enough to be understood by any reader. It well deserves to be studied now and retained as a reference book by all who are interested in the problem of control and eradication of tuberculosis.

Anatomy and Physiology, by Frederic T. Jung, M.D. and Elizabeth Earle, R.N. 829 pages. Published by F. A. Davis Co., Philadelphia. Canadian agents: The Ryerson Press, 299 Queen St. W., Toronto 2B. 3rd Ed. 1945. Illustrated. Price $4.00. *Reviewed by Jessie Cook, Instructress, Royal Victoria Hospital School of Nursing, Montreal.*

This interesting and practical textbook has been revised and brought completely up-to-date, particularly in regard to the correlative applications which serve to link up anatomy and physiology with other subjects in the nursing curriculum.

The material is well organized and easy to read. As in previous editions, a preview heads each chapter and topic, with the headings in blacker type. The summaries and many colored diagrams are excellent. Study projects, laboratory suggestions, and correlations are well chosen.

Certain topics are particularly well explained for the beginner. Of these, the short chapters on the ear, the introduction to the nervous system, and the summary of the digestive system and its chemistry are among the best. To the student who has difficulty in understanding the relationship between the blood and other body fluids, the chapter on the lesser circulatory system should prove very helpful.

The teacher who is seeking to make her subject more vital and stimulating to the student nurse will find this an excellent text.

Elementary Psychology, by Karl S. Bernhardt, Ph.D. 300 pages. Published by The Life Underwriters Association of Canada, Ste. 901, 159 Bay St., Toronto 1. 1943. Price $2.25.

Reviewed by Kathleen Marshall, Allan Memorial Institute, Montreal.

This book is a revision and expansion of a book published in 1934. It was written in the first place because the author felt that there was a real need for a book on psychology which could be understood by the person who had not had a college education and yet which contained the scientific viewpoint and accuracy of the college text. The subject is introduced by a brief historical survey of psychology from the primitive period to modern times where scientific workers verify and repeat all experiments. As efficiency is the keynote of business and industry today, the author discusses efficiency in reading and studying which would be valuable to anyone who reads a book. The origin and control of human behavior, including the influencing of other people, regulation of child behavior, and emotional control takes up Part 2, while Part 3, discussing the differences of individuals, includes intelligence and personality testing. Relations with other people, and a chapter on mental hygiene with fifteen suggestions for personal mental health, is very well done and would be of help to anyone who reads the book. To complete this work a glossary of psychological terms used and review questions for every chapter will be found at the end.

Victorian Order of Nurses

The following are the staff appointments to, transfers, and resignations from the various branches of the Victorian Order of Nurses for Canada:

Appointments: *Elizabeth (Whiston) Hackett* temporarily at Halifax; *Mildred Irwin* (Royal Jubilee Hospital, Victoria, and University of British Columbia public health course) to Calgary; *Elizabeth Skinner* (Stratford General Hospital and University of Western Ontario public health course) to Waterloo; *Grace Connor* (Toronto Western Hospital and University of Toronto public health course) to Belleville; *Jean (Howey) Brook* (Owen Sound General Hospital and University of Manitoba public health course) to Winnipeg; *Elsie White*, who received a Victorian Order scholarship and has completed the public health course at University of Western Ontario, as nurse-in-charge at Orillia.

Transfers: *Margaret Forry* from Burnaby to be nurse-in-charge at Elphinstone; *Betty Short* from Elphinstone to Burnaby; *Mary*

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Allen from Saint John to Peterborough; *Helen Thompson* from Border Cities to be nurse-in-charge at St. Thomas; *Marian Werry* from Belleville to open the new Chatham (N.B.) branch; *Bessie Bailie* from St. Thomas to Montreal.

Resignations: *Anna* (*McKenzie*) *Thorpe* from Halifax; *Jean Burgoin* from London; *Helen* (*Anderson*) *Grant* from Kitchener; *Mrs. Margaret Brown* from Vancouver and has retired from active nursing; *Normina MacLean* from Gananoque; *Jean Burgess* from Sackville, *Margaret McNabb* from Hamilton, and *Jeanette McInnis* from Peterborough, all to take up other work.

News Notes

BRITISH COLUMBIA

Trail-Tadanac Hospital:

Faith Hodgson is now assistant superintendent, replacing Nancy Robb who has held the position for three years. Miss Hodgson (Royal Jubilee Hospital, Victoria; Queen Alexandra Solarium for Crippled Children, Cobble Hill, B.C.; B.A., University of B.C.) served with the navy for over three years, when she saw service in Canada and Scotland. On her discharge she took the course in hospital administration at the McGill School for Graduate Nurses.

Other additions to the staff include June Sonmore, Doris Steffanick, Lillian McCallum, Camilla Heffernan, Ann Balfour, and Mrs. Bertha Cunnings. Alma (McKerral) McGauley is still on the staff. Mrs. D. Robinson has resigned.

MANITOBA

BRANDON:

At the opening meeting held by the Brandon Graduate Nurses Association, Mr. A. B. Downing gave an instructive talk on the importance of a library to any community. He pointed out the vast amount of work and organization it required to establish a library in any centre. Nan Crighton thanked the speaker who was introduced by Janet Smith.

NEW BRUNSWICK

SAINT JOHN:

A pleasant evening was spent when Saint John nurses had as their guest, Margaret Kerr, editor of *The Canadian Nurse*. Following her address a reception was held at the General Hospital.

Gertrude Maddox has completed her course at the University of Toronto and is now public health nurse for King's County. Helen Fitzgerald, Kathleen Mahoney, and Florence O'Hara, recently discharged from the R.C.A.M.C., are on the staff of the Montreal Veterans Hospital. Zita Parsons has resigned from the D.V.A. Lancaster Hospital to accept a position in Montreal. Rev. Sisters M. de Lellis and Helen Marie, of the staff of St. Joseph's Hospital, are attending the University of St. Louis. Sr. M. Germaine has been appointed to the staff of St. Joseph's Hospital. Virginia McDonald, of Souris, P.E.I., has been appointed to the school nursing service of the Saint John Board of Health. Mary G. Allen, of the V.O.N. staff, has been transferred to Peterborough.

General Hospital:

Mary E. MacDougall is attending the McKenzie School of Missions, Hartford, Conn., prior to going to the Angolo mission field, Africa. Crena Allen has succeeded Mrs. D. Eaton as supervisor, 4th floor, and E. Hooper is her assistant. Jane Stephenson, obstetrical supervisor, is on leave of absence and T. E. Brown is acting in her place. Phyllis Thomas has resigned from the O.R. staff.

ST. STEPHEN:

The St. Stephen Chapter, N.B.A.R.N., gave a banquet at the Chipman Memorial Hospital in honor of Margaret Kerr, editor of *The Canadian Nurse.* Miss Kerr gave an interesting talk on how the *Journal* is prepared for publication, and several subscriptions were received. A vote of thanks was tendered by Myrtle Dunbar.

At a recent monthly meeting of the chapter the newly-elected president, Miss Dunbar, was in the chair. The drawing for two pairs of nylon stockings, donated by Reta Follis and Clara Dowling, in aid of the British Nurses Relief Fund, took place, the winner being Mrs. M. McCrum. The sum of $102 was forthcoming. The final parcel to be sent to a Dutch nurse was assembled by Mrs. McCrum and Mrs. E. Mehan. Money was voted for a wreath to be placed on the Cenotaph.

NOVA SCOTIA

HALIFAX:

Victoria General Hospital:

The Victoria General Hospital Alumnae Association had an interesting program during the past year under the convenership of M. Ripley, with Mrs. E. Williams as co-convener. The following are some of the highlights of their activities: Pictures, which had been purchased by the alumnae for the nurses' residence, were formally presented to the hospital by the president. Frances MacDonald, acting superintendent of nurses, and Dr. J. E. Hiltz, acting medical superintendent, gave short addresses. An address was given by Lieut. Col. H. D. O'Brien, R.C.A.M.C., on his service overseas. The alumnae entertained the 1945 graduating class at a buffet supper. A Christmas sale was held which realized the sum of $215.42. The executive members of the Halifax Infirmary and Nova Scotia Hospital were special guests at a tea, which included a musical program. Also present were many V.G.H. graduates who had served in the armed forces. An interesting address on "Psychotherapy and Treatments of the Psychiatric Patient" was given by Dr. R. O. Jones. At the final meeting of the season the newly-appointed medical superintendent of the hospital, Dr. C. Bethune, gave a short talk.

Recently, an enjoyable party was tendered the graduating class by the alumnae when entertainment included acrobatic dances and vocal selections. Mrs. J. T. Luscombe, the president, was in charge of the business session, when a report was given by Dorothy Gill on the R.N.A.N.S. annual meeting held in Amherst.

The officers for the coming season include D. Gill as vice-president, with Mrs. E. Stanley serving as secretary, and Mrs. H. S. T. Williams as treasurer.

ONTARIO

EDITOR'S NOTE: District officers of the Registered Nurses Association may obtain information regarding the publication of news items by writing to the Provincial Convener of Publications, Miss Gena Bamforth, 54 The Oaks, Bain Ave., Toronto 6.

DISTRICT 4

The first regular meeting of the season of Niagara Peninsula Chapter, District 4, R.N.A.O., was held at the Niagara Falls General Hospital. An executive meeting was held prior to the regular gathering, when

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the new president, Catharine O'Farrell, was in the chair. There was an attendance of forty-eight. Miss O'Farrell gave an interesting report of the C.N.A. biennial convention. Mr. G. H. Hamilton, M.A., M.Sc., was the guest speaker and his subject, "Medicinal Plants", was found extremely interesting. Bernice Lousley thanked the speaker. Refreshments were served by Mrs. H. McGarry and her committee.

DISTRICT 7

BROCKVILLE:

In May the Brockville General Hospital Alumnae Association entertained the 1946 graduating class and the hospital staff at dinner. Mmes Margaret Eland and Phyllis Wooding provided vocal and piano music. Mrs. W. E. Cook, vice-president, was chairman for the after-dinner program. Helen Corbett proposed the toast to the new graduates to which Miss Channez Algie replied. The superintendent of nurses, Geneva Purcell, announced the prize awards. The highlight of the evening was the address by Gertrude Hall, general secretary, C.N.A., and her talk was much enjoyed. She was thanked on behalf of those present by Maude Arnold.

When E. Claw celebrated the fiftieth anniversary of her graduation from the school of nursing, the alumnae entertained in her honor at tea. A presentation was made to her of a bouquet of roses. Miss Claw practised private duty for many years and is now enjoying her retirement.

Mary Hemphill is on the supervisory staff. Edith Dewar is assistant operating-room supervisor. Dorothy Aitken, who recently completed a post-graduate course in obstetrics at Royal Victoria Hospital, is obstetrical supervisor. Dorothy Barrett, night supervisor, has been granted leave of absence to attend the University of Toronto.

KINGSTON:

Public health service in Kingston has been expanded to cover the secondary as well as the primary schools. Active Home and School Clubs have been stressing both mental and physical preventive measures in regard to all students.

Hotel Dieu Hospital:

Dr. Edwin Robertson was guest speaker at the hospital recently when he exhibited wax models which depicted various gynecological and endocrine conditions. He explained an interesting new development in the classification of all medical conditions, every patient being placed in one of three groups, eliminating the possibility of diseases affecting those in either of other two classifications.

Kingston General Hospital:

The interest of all nurses has been centred on the progress of the Victory Wing of the K.G.H. which will feature the most recent developments in the diagnosis and treatment of cancer. A widespread educational campaign among service clubs, women's organizations, and the community at large is being carried out and plans have been made to make treatment at the new clinic within financial reach of all.

Ontario Hospital:

The alumnae association recently entertained members of the 1945-46 graduating class at a luncheon, when each graduate was presented with a tiny bud vase, membership in the alumnae, and a corsage. Representatives from local hospitals and nursing organizations were guests, Major J. Stewart Crawford being the principal speaker. Dr. J. S. Stewart also addressed the class. Mrs. J. B. Garvin was mistress of ceremonies. Mmes A. Jarvis and F. Prudhomme were present from out of town.

Mrs. Edith Alexander, of the training school staff, has been replaced by B. Jones. Mrs. Alexander was presented with a small gift from the association on her departure.

SMITHS FALLS:

All who are aware of the need for expansion in regard to mental hospital accommodation will welcome the construction now underway of the Ontario Hospital for Mental Defectives.

DISTRICT 8

Ottawa Civic Hospital:

As a mark of affection and appreciation of her services to hundreds of nurses who passed under her guidance at the Civic Hospital, the alumnae association recently honored the retiring director of nurses, Gertrude Bennett. About 350 nurses were in attendance, including not only many O.C.H. graduates, but also nurses from the Lady Stanley and St. Luke's alumnaes and from many schools of nursing across Canada. Pearle Farmer received the guests who were welcomed by Miss Bennett, wearing a corsage of orchids, a gift of the alumnae, and Isobel Dickson, president of the alumnae. Pointing to the appreciation of Miss Bennett's leadership in nursing activities was the presentation of a purse containing a $1,000 bond. Mrs. G. W. Dunning read an illuminated address, expressing admiration for Miss Bennett and regret at her departure from Ottawa. Conveners were Mrs. E. True and Evelyn Horsey. Emily Maxwell, M.B.E., Jean Vizard, Gertrude Garvin, Mabel Stewart, Mmes M. E. Jones, and R. Stewart assisted with the serving.

An entertainment was held by the alumnae in honor of Blanche Anderson and Grace Tanner on their resignation from the staff, when they were presented with pocket books and corsages.

QUEBEC

MONTREAL:

Homoeopathic Hospital:

E. Hawke has returned from Baltimore, where she completed a course in O.R. technique at Johns Hopkins Hospital, to replace Mrs. Holland on the O.R. staff. E. Geddes, who was employed as an industrial nurse during the war, is now 2nd floor supervisor,

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relieving Miss Mapes who is taking the teaching and supervision course at McGill School for Graduate Nurses. Janet Cassidy, recently discharged from the R.C.A.M.C., is assistant supervisor, 2nd floor, replacing Miss Orr who is now Mrs. Vanderbilt and living in the U.S.A. G. Bailey, who has done private duty for the past year, is supervisor, 4th floor. She replaces Miss Bryant who is taking teaching and supervision at McGill. Miss Brooke has replaced Mabel (MacMillan) Pasquet as supervisor of the P.O.R.R. and blood bank. Ruth (Blennerhassett) Hall and Eileen (MacLeod) Beauchamp have resigned from the staff. V. Payne has returned to her home in Pictou, N.S.

Jewish General Hospital:

The first open meeting of the season of the Associate Nurses took the form of the annual dinner when forty-three members attended. Faye Fox, president, welcomed those present and a few words were said at the close of the dinner by Amy Mendels, honorary president and superintendent of nurses.

The fund-raising project of the year is to be the raffling of a mantle radio. Raffle books were distributed at the dinner and members not present are asked to contact Ann Harrow, AT 1131, for their books.

Royal Victoria Hospital:

The staff of the hospital was well represented at a motion picture on "Operating-Room Technique" given by Davis and Geck at the Windsor Hotel.

Recent visitors to the school of nursing included Mrs. Berta (Colwell) Crosby, of Halifax, and Janet Cook, who will reside in Arizona.

Laureena Wright has accepted a position with the Saskatchewan Department of Public Health and will be stationed with Health Unit No. 14, Meadow Lake. Miss Pirie is employed with the National Research Council at the Royal Edward Laurentian Hospital, Ste. Agathe. Margaret Holder has returned to Montreal after several years with the V.O.N. in Nova Scotia. Shirley Lewis and Elizabeth Armstrong are taking public health at McGill. Katherine Gibson is now living in Vancouver.

St. Mary's Hospital:

The St. Mary's Hospital Alumnae Association recently held its annual communion breakfast at the Windsor Hotel. Many members were present to hear the Rev. Fr. S. L. Wiercinski who spoke on "The Theology of Marriage." Mrs. T. Wheatley thanked the speaker. Prior to breakfast, mass was attended at St. Patrick's Church.

QUEBEC CITY:

Frances Upton, registrar of the R.N.A.P.Q., was the guest speaker at the first fall meeting of Jeffery Hale's Hospital Alumnae Association. Her interesting talk on nursing conditions of today, and on the Nursing Act and its benefits to the nurses in Quebec province, was greatly enjoyed by those present.

At a later meeting G. Martin, of the teaching department, gave a résumé of the

C.N.A. convention which she attended. Miss Fischer, who went to the R.N.A.P.Q. annual meeting in Montreal as a representative from the alumnae and also from the provincial association, gave an informative report. Misses Martin and Fischer were thanked by Mrs. L. Seale and M. Lunam.

The outdoor department has been expanded and L. Eager is in charge, having recently returned from active service with the R.C.A.M.C. and the South African Military Nursing Service. The following nurses are doing general duty at J.H.H.: B. MacKinnon, E. Christensen, A. Grimmer, N. MacIntosh, E. Applegate, D. Moores. N/S Joan Warren is stationed in Calgary. I. Matthews (South African Military Nursing Service) is assistant night supervisor. F. M. Taylor (Royal Canadian Naval Nursing Service) is assisting in the x-ray department and on the surgical staff. N. Humphries (R.C.A.M.C.) is back at her former position as O.R. supervisor. C. Flett is now assistant to the laboratory technician. E. Farquhar (Royal Canadian Naval Nursing Service) is on the staff of the D.V.A. hospital in Sydney, N.S.

SASKATCHEWAN

ESTEVAN:

A very successful bazaar and tea were held by the Estevan Chapter recently. Clara Jackson, travelling instructor, S.R.N.A., visited the chapter at which time she gave an interesting address.

HUMBOLDT:

Teresa Bevan is relieving at St. Michael's Hospital, Cudworth. Ven. Sr. Florianne, operating-room supervisor, has been appointed Sister Superior at St. Joseph's Hospital, Macklin, and has been replaced by the Ven. Sr. Dolores, of Macklin.

PRINCE ALBERT:

Nurses were invited to Victoria Hospital to hear Dr. Setka tell of his trip to the Kenny Institute in Minneapolis. A film was shown and an interesting discussion followed. Miss Leach has joined the staff of the Holy Family Hospital. Miss Lindsley has left the hospital to take the air stewardess course in Winnipeg.

REGINA:

Katherine McLellan is now on the V.O.N. staff.

Grey Nuns' Hospital:

A heartiest welcome is extended to Rev. Sr. Brodeur who is now superintendent of nurses.

Regina General Hospital:

The nursing staff recently held a miscellaneous shower in honor of M. Nell and W. Odling who are to be married. Thelma Caulder, O. Christie, G. Thompson, and L. Skuce are additions to the nursing staff.

SASKATOON:

St. Paul's Hospital:

Marvalon Robinson, president of St. Paul's Hospital Alumnae Association, gave a valuable account of the C.N.A. convention at the

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September meeting. Capt. F. S. Murray, M.D., was guest speaker at a later meeting, when he gave an address on "Psychiatry," referring to particular cases he had dealt with in the army.

The hospital now has new x-ray equipment and a radiologist has been appointed. Rev. Mother Provincial was welcomed to St. Paul's recently, along with Miss Robertson, V.O.N., and Miss Miller who visited the school of nursing. M. Lenz replaces Miss Gunther on the staff.

Saskatoon City Hospital:

The Saskatoon City Hospital Alumnae Association held a reunion dinner at the Bessborough Hotel when approximately 130 graduates were present, representing classes from 1914 to 1946. K. W. Ellis was the guest speaker.

SWIFT CURRENT:

Newly elected officers for the Swift Current Chapter, S.R.N.A., include: president, Mrs. Marie Nodge; vice-president, Mrs. Ethel Toole; secretary, Mrs. E. Powley; treasurer, Bessie Young.

WEYBURN:

The second meeting of Weyburn Chapter, No. 8, S.R.N.A., was held at the home of Dr. Baines when the following officers were elected: president, Mrs. H. Mitchell; secretary-treasurer, M. Casky; vice-president, M. MacDonald; news reporter, V. Wiens. Clara Jackson, director of nurse placement service for Saskatchewan, was the guest speaker, and her visit was much enjoyed by all present. Several new members have been welcomed to the chapter.

D. Hogyard will leave for Prince George shortly. Mary and Alice MacDonald are to take up public health.

YORKTON:

Much interest was shown by the members in the travelling handicraft exhibit on display at the October meeting of the chapter. Seventeen students have commenced their training at the General Hospital. Among recent appointments to the hospital staff M. Crawford, of Fort San, is science instructress. I. Wagner has resigned as ward supervisor. A. Simair is on the general nursing staff of the obstetrical department.

BERMUDA

King Edward VII Memorial Hospital:

Jonete McDougall (Montreal General Hospital) is now instructor on the staff. Bernice C. Underhill, a member of the staff since 1938 as instructor, and assistant matron since December, 1942, is taking a post-graduate course at Vanderbilt University, Tenn.

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Assistant Director of Nursing. Apply, stating qualifications and experience, to Director of Nursing, General Hospital, Belleville, Ont.

Registered Nurses for General Duty at Vancouver General Hospital, British Columbia. State in first letter date of graduation, experience, reference, etc., and when services would be available. 8-hour day and 6-day week. Gross salary: $125 per month living out, with annual increases up to 7 years, plus laundry. 1½ days sick leave per month accumulative with pay. Employees' Hospitalization Society. Superannuation. 1 month vacation each year with pay. Investigation should be made with regard to registration in British Columbia. Apply to Director of Nurses.

Public Health Nurses with agency specializing in Tuberculosis. Health education and case finding program. Home visiting and clinic duties. No bedside nursing. Experience in tuberculosis preferred but not essential. Nurses without Public Health training desiring experience in this field accepted on temporary basis. Apply to Royal Edward Laurentian Hospital, Dept. of Public Health Nursing, 3674 St. Urbain St., Montreal 18, P.Q.

Public Health Nurses for Bruce County Health Unit. Salary: $1,500 to $1,800 according to experience, plus car allowance. Apply to W. S. Forrester, Secretary, Paisley, Ont.

Assistant Operating-room Supervisor for Victoria Hospital, London, Ontario. Bed capacity, 575. Good salary and full maintenance. Post-graduate and practical experience very desirable. Apply, stating school and year of graduation, age, details of experience, references, and date of availability for service, to Supt. of Nurses.

General Duty Nurses. Salary: $100 per month with full maintenance; $105 per month with full maintenance, while on night duty, which comes one month in each 4 months. 6-day week. 3 weeks'vacation with pay annually. Apply to Supt., Lady Minto Hospital, Cochrane, Ont.

Operating-room Supervisor, Pediatric Supervisor, Nursing Arts Instructor. Fully qualified. Full maintenance provided. Apply, stating qualifications, experience, and salary expected, to Lady Supt., General Hospital, Dauphin, Man.

Operating-room Nurses and Assistant Night Supervisor with knowledge of obstetrics. Full maintenance. Apply, stating qualifications and experience, to Supt. of Nurses, General Hospital, Saint John, N.B.

Instructress of Nurses. Salary: $140 per month and full maintenance. Apply to Supt., General Hospital, Kenora, Ont.

Night Supervisor. Alternating 3-11 and 11-7. Salary: $120 per month and maintenance. For further particulars write to Supt. of Nurses, Public Hospital, Lamont, Alta.

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Someone living in Regina mailed a postal note for two dollars and a blank subscription form to the *Journal* recently. The postal note is stamped with the date November 12, 1946. Will the anonymous subscriber please write to the *Journal* giving her name and address? The postal note number will identify the subscription, so please include that with your letter.

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PROVINCIAL EXECUTIVE OFFICERS

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Registered Nurses Ass'n of British Columbia: Miss Alice L. Wright, 1014 Vancouver Block, Vancouver.

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New Brunswick Ass'n of Registered Nurses: Miss Alma F. Law, 29 Wellington Row, Saint John.

Registered Nurses Ass'n of Nova Scotia: (*Acting*) Miss Nancy Watson, 301 Barrington St., Halifax.

Registered Nurses Ass'n of Ontario: Miss Matilda E. Fitzgerald, Rm. 715, 86 Bloor St. W., Toronto 5.

Prince Edward Island Registered Nurses Ass'n: Miss Helen Arsenault, Provincial Sanatorium, Charlottetown.

Registered Nurses Ass'n of the Province of Quebec: Miss E. Frances Upton, 1012 Medical Arts Bldg., Montreal 25.

Saskatchewan Registered Nurses Ass'n: Miss Kathleen W. Ellis, 104 Saskatchewan Hall, University of Saskatchewan, Saskatoon.

Provincial Associations of Registered Nurses

ALBERTA

Alberta Association of Registered Nurses

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Ponoka District, No. 2, A.A.R.N.

Pres., Miss Doris Smith; Vice-Pres., Miss Virginia Deming; Sec.-Treas., Miss Nessa Leckie, Provincial Mental Hospital, Ponoka; *Reps.* to: *Nurse Placement Service*, Miss Eleanor Stark; *Labor Relations*, Miss Mildred Nelson; *The Canadian Nurse*, Miss Florence Konkin.

Calgary District, No. 3, A.A.R.N.

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Medicine Hat District, No. 4, A.A.R.N.

Pres., Miss Margaret Dann; Vice-Pres., Miss Ina Lankinen; Sec.-Treas., Miss Donalda Gardner, Ste. 2., 549-3rd St.

Red Deer District, No. 6, A.A.R.N.

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BRITISH COLUMBIA

Registered Nurses Association of British Columbia

Pres., Miss E. Mallory, University of B.C., Vancouver; Vice-Pres., Misses E. Palliser, E. Clark; Hon. Sec., Miss E. Paulson; Hon. Treas., Mrs. E. Pringle; Past Pres., Miss G. Fairley; *Section Chairmen: General Nursing*, Miss E. Otterbine, Ste. 5, 1334 Nicola St., Vancouver; *Hospital & School of Nursing*, Miss E. Davis, Ste. 22, 1311 Beach Ave., Vancouver; *Public Health*, Miss P. Reeve, 3137 W. 42nd Ave., Vancouver; *District Councillors: Central Interior*, Mrs. M. Brolin; *East Kootenay*, Mrs. E. Kelman; *Fraser Valley*, Miss M. Hamilton; *Greater Vancouver*, Misses E. Gilmour, I. Goward, F. Rowell; *Kamloops-Okanagan*, Miss O. Garrood; *Vancouver Island*, Misses M. Fletcher, S. Porritt; *West Kootenay*, Miss A. K. Williams; Director, Placement Service, Miss Elizabeth Braund, 1001 Vancouver Block, Vancouver; Executive Secretary & Registrar, Miss Alice L. Wright, 1014 Vancouver Block, Vancouver.

New Westminster Chapter, R.N.A.B.C.

Hon. Pres., Misses C. E. Clark, E. H. Gouldburn; Pres., Mrs. G. Grieve; Vice-Pres., Miss Avery; Sec., Miss M. Hamilton, 1025-8th Ave.; Treas., Mrs. H. Blackburn, 1814 Dublin St.; *Rep.* to *The Canadian Nurse*, Miss Furness, R.C.H.

Vancouver Island District

Victoria Chapter, R.N.A.B.C.

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East Kootenay District

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MANITOBA

Manitoba Association of Registered Nurses

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New Brunswick Association of Registered Nurses

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District 7

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District 8

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Chairman, Miss S. Laine; Vice-Chairman, Miss A. Walker; Sec., Miss D. Lemery, 12 Kay Blk., Kirkland Lake; Treas., Miss Jean Smith, Muskoka Hospital, Gravenhurst; *Committee Conveners: General Nursing*, Mrs. E. Sheridan; *Public Health*, Miss G. McArthur; *Membership*, Miss R. Densmore; *Epidemics*, Miss Black; *Rep.* to *The Canadian Nurse*, Miss Elizabeth Smith.

District 10

Chairman, Miss M. Spidell, Port Arthur General Hospital; Vice-Chairman, Miss W. Ballantyne; Sec.-Treas., Miss Isabelle Morrison, 345 N. Archibald St., Fort William; *Section Conveners; Hospital & School of Nursing*, Miss D. Shaw; *Public Health*, Miss B. Jackson; *General Nursing*, Mrs. P. Spottiswood; *Councillors*, Misses O. Waterman, A. Baillie, A. Hunter, J. Hogarth, Mrs. R. Gagnon, Sr. Sheila.

PRINCE EDWARD ISLAND

Prince Edward Island Registered Nurses Association

Pres., Miss Dorothy Cox, 101 Weymouth St., Charlottetown; Vice-Pres., Mrs. Lois MacDonald, P.E.I. Hospital, Charlottetown; Prov. Sec., Miss Helen Arsenault, Provincial Sanatorium, Charlottetown; Treas. & Registrar, Sr. M. Magdalen, Charlottetown Hospital; *Section Chairmen: Public Health*, Miss Eleanor Wheler, Summerside; *General Nursing*, Miss Mildred Thompson, 20 Euston St., Charlottetown; *Hospital & School of Nursing*, Sr. Mary Irene, Charlottetown Hospital.

QUEBEC

Registered Nurses Association of the Province of Quebec (Incorporated 1920)

Pres., Miss E. C. Flanagan; Vice-Pres. (*English*), Miss M. S. Mathewson; Vice-Pres. (*French*), Rev. Soeur Valérie de la Sagesse; Hon. Sec., Miss E. B. Cooke; Hon. Treas., Mlle A. Martineau; *Members without Office*, Misses F. Munroe, V. Graham, A. Peverley, G. Yeats, Mlles M. Taschereau (Québec), J. Lamothe (Three Rivers), P. Crevier, E. Mercier F. Goyette; *Advisory Board*, Misses C. V. Barrett, C. M. Ferguson, C. Livingston, M. E. Lunam, G. M. Hall, Rev. Sr. M. Adalbert, Rev. Soeurs M. Horace, G. Majella, Mlles M. Roy, M. Beaumier, Mme A. D. Bernier; *Conveners of Sections: Hospital & School of Nursing* (*English*), Miss D. Parry, Children's Memorial Hospital, Montreal 25; (*French*), Rev. Sr. Denise Lefebvre, Institut Marguerite d'Youville, Montreal 25; *Public Health* (*English*), Miss S. Levinson, 4707 Jeanne Mance St., Montreal 8; (*French*), Mlle A. Girard, Ecole d'Infirmières Hygiénistes, Université de Montréal; *General Nursing* (*English*), Miss E. Killins, 3533 University St., Montreal 2; (*French*), Mlle A. M. Robert, 3677 rue Ste-Famille, App. 28, Montréal 18; *Boards of Examiners* (*English*), Miss M. S. Mathewson (chairman), Misses E. Allder, M. Flander, C. Aitkenhead, K. Stanton, Mrs. S. Townsend; (*French*), Rev. Sr. Rheault (chairman), Rev. Soeurs Paul du Sacré-Coeur, Marcellin, Jeanne de Lorraine, Mlles M. Beaumier, J. Trudel; Executive Secretary, Registrar & Official School Visitor, Miss E. Frances Upton, 1012 Medical Arts Bldg., Montreal 25; Official School Visitor (*French*), Mlle S. Giroux, 504 Medical Arts Bldg., Montreal 25.

District 1

Chairman, Mlle M. Ange Chamard, New Carlisle, Cté Bonaventure, P.Q.; Sec., Mlle M. Bugeaud, New Carlisle, Cté Bonaventure, P.Q.

District 2

Chairman, Rvde Soeur Ste-Marie Madeleine, Hôtel-Dieu, Lévis, P.Q.; Sec., Mlle Jeanne d'Arc Beaudoin, Hôtel-Dieu, Lévis, P.Q.

District 3

English Chapter: Chairman, Mrs. N. S. Lothrop, 85 London St., Sherbrooke, P.Q.; Sec., Mrs. E. E. Messenger, 60 Ontario St., Sherbrooke, P.Q. *French* Chapter: Chairman, Mlle Rita Aubin, East Angus, Cté Compton, P.Q.; Sec., Mlle Jeannine Goulet, 117 rue Conseil, Sherbrooke, P.Q.

District 4

Chairman, Mlle Laure Ménard, Hôpital St-Charles, St. Hyacinthe, P.Q.; Sec., Mlle Claire Lemonde, Hôpital St-Charles, St. Hyacinthe, P.Q.

District 5

Chairman, Mlle Maria H. Beauregard, 228 rue Collin, St-Jean, P.Q., Sec., Mlle Madeleine Gauthier, 208 rue Bouthillier, St-Jean, P.Q.

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Chairman, Rvde Soeur Thomas du Sauveur, Hôpital du Sacré-Coeur, Hull, P.Q.; Sec., Mlle Gabriel Parke Hôpital Youville, Noranda, P.Q.

District 7

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District 8

Chairman, Mlle Alma Benoit, C.P. 66, Trois-Rivières, P.Q.; Sec., Mlle Gertrude Parent, 795 rue, St. Roch, Trois-Rivières, P.Q.

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District 10

Chairman, Mlle Laureanne Couet, 162 Rivière du Moulin, Chicoutimi, P.Q.; Sec., Mlle Josephine Simard, C.P. 272, Chicoutimi, P.Q.

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SASKATCHEWAN

Saskatchewan Registered Nurses Association (Incorporated 1917)

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Alumnae Associations

ALBERTA

A.A., Calgary General Hospital

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A.A., Holy Cross Hospital, Calgary

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A.A., Edmonton General Hospital

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A.A., Lamont Public Hospital

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BRITISH COLUMBIA

A.A., St. Paul's Hospital, Vancouver

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A.A., Vancouver General Hospital

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A.A., Royal Jubilee Hospital, Victoria

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A.A., St. Joseph's Hospital, Victoria

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MANITOBA

A.A., St. Boniface Hospital

Hon. Pres., Rev. Sr. Clermont; Pres., Miss L. Thompson; Vice-Pres., Misses M. Wilson, M. McKenzie; Rec. Sec., Miss M. Lougheed; Corr. Sec., Miss B. McPherson, St.B.H.; Treas., Mrs. B. Smith; *Archivist*, Mrs. T. Hulme; *Committee Conveners: Visiting*, Miss D. Hurle; *Social*, Mrs. M. Gendall; *Membership*, Miss B. Sotkowsky; *Reps.* to: *M.A.R.N.*, Miss N. Craig; *Nurses' Directory*, Miss E. Gagnon; *Local Council of Women*, Miss S. Wright; *The Canadian Nurse*, Mrs. H. Lemoine.

A.A., Children's Hospital, Winnipeg

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A.A., Misericordia General Hospital, Winnipeg

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A.A., Winnipeg General Hospital

Hon. Pres., Mrs. A. W. Moody; Pres., Miss L. Gunn; Vice-Pres., Misses F. Waugh, R. Monck, J. Morgan; Rec. Sec., Miss H. Reid; Corr. Sec., Miss S. Ross, Ste. 10 Balmoral Crt.; Treas., Miss A. Smith, 806 Sherburn St.; *Committee Conveners: Program*, Mrs. F. Wilson; *Membership*, Miss V. Walker; *Visiting*. Miss A. Aikman; *Journal*, Miss J. Simmie; *Archivist*, Miss L. Higginbottom; *Sandford Scholarship Fund*, Miss I. Cooper; *Reps.* to: *School of Nursing*, Miss F. Waugh; *Doctors' & Nurses' Directory*, Miss E. English; *Local Council of Women*, Mmes P. Randall, Thomas; *Council of Social Agencies*, Mrs. A. Speirs; *Red Cross*, Miss G. Hayden; *The Canadian Nurse*, Miss B. Hunt.

NEW BRUNSWICK

A.A., Saint John General Hospital

Hon. Pres., Miss E. J. Mitchell; Pres., Miss S. Hartley; First Vice-Pres., Miss M. Foley; Sec., Vice-Pres., Miss M. Scott; Sec., Miss K. Lawson, 140 Elliott Row; Treas., Mrs. A. E. Handren, Belmont, R.R. 1; *Executive*, Misses M. Murdoch, M. Ronald; *Conveners: Program*, Miss D. Wetmore, Mrs. Denyer; *Social*, Mrs. Lewin; *Flower*, Miss Selfridge; *Refreshment*, Mrs. B. Watt; *Publicity*, Miss I. Clark; *Visiting*, Mrs. A. Burns.

A.A., L. P. Fisher Memorial Hospital, Woodstock

Pres., Mrs. George King, Broadway; Vice-Pres., Mrs. W. B. Manzer, Chapel St.; Sec., Mrs. John Charters, Elm St.; Treas., Mrs. Elmer Arnold, Elm St.; *Executive Committee*, Mrs. Bertrum Gardiner, Prince William St.; Mrs. Thomas Everett, Union St.; Mrs. John Hale, Pine St.

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A.A., Halifax Infirmary

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A A., Victoria General Hospital, Halifax

Pres., Mrs. J. T. Luscombe; Vice-Pres., Miss D. Gill; Sec., Mrs. Eric Stanley, 50 Beech St.; Treas., Mrs. H. S. T. Williams, 362 Spring Garden Rd.; *Board of Directors*, Mmes V. Gormley, W. Hunt, M. Smith; *Committee Conveners: Visiting*, Mrs. A. MacQuade; *Program & Entertainment*, Mrs. J. Churchill, Miss E. Atkinson; *Maritime Hospital Service*, Miss M. Archibald.

A.A., Aberdeen Hospital, New Glasgow

Hon. Pres., Miss Nina Grant; Pres., Miss Mabel Grant; Vice-Pres., Mrs. Claude Sutherland; Sec., Miss Vera MacIntosh, 154 Maple Ave.; Treas., Mrs. James Collie; *Rep.* to *Press*, Mrs. A. M. MacLeod.

ONTARIO

A.A., Belleville General Hospital

Hon. Pres., Miss E. Horton; Pres., Miss E. Sullivan; Vice-Pres., Misses A. Jones, R. Poole; Sec., Miss B. Sharland; Treas., Miss A. Howes; *Committee Conveners: Flower & Gift*, Miss M. Miles; *Social*, Misses D. McCall, M. Goodfellow; *Program*, Mrs. M. Devine; *Nominating*, Miss T. Gordon: *Reps.* to: *V.O.N.*, Mrs C. Howie; *The Canadian Nurse & Press*, Miss U. McComb.

A.A., Brantford General Hospital

Hon. Pres., Miss J. M. Wilson; Pres., Miss O. Plumstead; Vice-Pres., Mrs. J. MacKay; Sec., Miss M. Patterson, B.G.H.; Treas., Miss H. Scott; *Committees: Gift*, Misses J. Landreth, V. Buckwell; *Flower*, Misses L. Burtch, A. Scott; *Social*, Mmes G. Brittain, D. Green; *Reps.* to: *Local Council of Women*, Mrs. R. Billo; *The Canadian Nurse & Press*, Miss I. Feely.

A.A., Brockville General Hospital

Hon. Pres., Misses A. Shannette, E. Moffatt; Pres., Mrs. M. White; First Vice-Pres., Mrs. W. Cooke; Sec. Vice-Pres., Miss L. Markley; Sec., Mrs. H. Bishop, 89 King St. W.; Corr. Sec., Miss M. Arnold, William St.; Treas., Mrs. H. Vandusen; *Committees: Gift*, Miss V. Kendrick; *Social*, Mrs. H. Green; *Property*, Mrs. M. Derry, Misses J. McLaughlin, M. Gardiner; *Annual Fees*, Miss V. Preston; *Rep.* to *The Canadian Nurse*, Miss H. Corbett.

A.A., Public General Hospital, Chatham

Hon. Pres., Miss P. Campbell; Pres., Mrs. H. Goldrick; Vice-Pres., Mrs. D. Nicholls, Miss E. Phillips; Rec. Sec., Miss E. Miller; Corr. Sec., Miss M. Gilbert, 220 St. Clair St.; Assist. Corr. Sec., Mrs. L. Judd; Treas., Miss D. Thomas; *Committees: Shopping*, Misses A. Head, E. Liberty, Mrs. G. Brisby; *Social & Refreshment*, Mmes J. C. MacWilliam, R. Bradley, Misses A. Hastings, M. Campbell; *Councillors*, Misses L. Baird, V. Dyer, M. McNaughton, A. Head; *Reps.* to: *Press*, Miss J. Murray; *The Canadian Nurse*, Mrs. M. Sheldon.

A.A., St. Joseph's Hospital, Chatham

Hon. Pres., Sr. M. Fabian; Hon. Vice-Pres., Sr. M. Valeria; Pres., Miss J. Coburn; Vice-Pres., Mmes B. Caron, L. Smyth; Sec.-Treas., Miss D. Carley; Corr. Sec., Miss A. Kenny, Aberdeen Hotel; *Councillors*, Misses H. Gray, L. Pettypiece, Mmes E. Roberts, E. Peco; *Committees: Lunch*, Miss M. Newcomb, Mmes H. Kennedy, M. O'Rourke; *Buying*, Mmes E. Roberts, E. Peco; *Program*, Misses M. Boyle, K. Kaufmann, Mmes C. I. Salmon, F. Doyle; *Reps.* to: *Press*, Miss K. Kaufmann; *The Canadian Nurse*, Mrs. M. Jackson.

A.A., Cornwall General Hospital

Hon. Pres., Miss H. C. Wilson; Pres., Miss C. Smirl; Vice-Pres., Mmes A. Snow, E. Wagoner; Sec.-Treas., Miss V. McMurray, 120 Adolphus St.; *Committee Conveners: Program & Social Finance*, Misses A. McNaughton, K. Brownell; *Flower*, Miss E. McIntyre; *Membership*, Miss Brownell; *Rep.* to: *The Canadian Nurse*, Mrs. G. Whitney.

A.A., Hotel Dieu Hospital, Cornwall

Hon. Pres., Rev. Sr. St. George; Pres., Miss D. Ryan; Vice-Pres., Rev. Sr. Mooney; Sec.-Treas., Miss H. Cleary; Corr. Secs., Miss A. Huot, St. Lawrence Sanatorium; Mrs. R. Ezard; *Committee Conveners: Music & Social*, Miss E. Young; *Gift*, Miss I. McDonell; *Publicity*, Miss U. Leblanc.

A.A., Galt Hospital

Hon. Pres., Miss Z. M. Hamilton; Pres., Miss H. Blagden; Sec., Miss Hilda Teather, Galt Hospital; Treas., Mrs. Vanstone; *Committee Conveners: Press*, Mrs. W. Bell; *Flower & Gift*, Mrs. J. Kersh; *Social*, Miss A. Park, Mrs. L. Maddock.

A.A., Guelph General Hospital

Hon. Pres., Miss S. A. Campbell; Past Pres., Mrs. C. McLeod; Pres., Mrs. W. Redmond; First Vice-Pres., Mrs. J. Tawse; Sec. Vice-Pres., Miss L. Brindle; Sec., Miss F. Cameron, 210 Woolwich St.; Treas., Miss K. Cleghorn.

A.A., St. Joseph's Hospital, Guelph

Mother Superior, Sr. M. Clotilde; Supt. of Nurses, Sr. M. Assumption; Pres., Miss E. Goetz; Vice-Pres., Miss H. Farrell; Sec., Miss M. Daley, 134 Ferguson St.; Treas., Miss J. Bosomworth, St.J.H.; *Entertainment Convener*, Miss B. Crimmins.

A.A., Hamilton General Hospital

Hon. Pres., Miss C. E. Brewster; Pres., Miss Ella Baird; Vice-Pres., Misses H. Fasken, E. Ferguson; Rec. Sec., Miss C. Leleu; Assist. Sec., Miss J. Tufford; Corr. Sec., Miss D. Pearce, H.G.H.; Treas., Miss N. Coles, 499 Main St. E.; Assist. Treas., Mrs. A. Smith; Sec.-Treas., Mutual Benefit Ass'n, Miss J.

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A.A., Ontario Hospital, Hamilton

Hon. Pres., Miss K. E. Turney; Hon. Vice-Pres., Miss E. P. Dodd; Pres., Mrs. M. Sutherland; Vice-Pres., Mrs. G. Wallace; Sec., Mrs. I. Nichols, Apt. 7, 23 St. Matthews Ave.; Treas., Miss M. Shalla; *Committee Conveners: Social*, Mrs. A. Smith, Misses M. Smith, M. MacDonald; *Visiting*, Miss E. Lee; *Rep.* to: *Press*, Miss D. Parker.

A.A., St. Joseph's Hospital, Hamilton

Hon. Pres., Rev. Sr. M. St. Edward; Hon. Vice-Pres., Rev. Sr. M. Ursula; Pres., Mrs. S. Hudecki; Vice-Pres., Miss F. O'Brien; Sec., Miss B. Clohecy, 56 East Ave. S.; Treas., Miss J. O'Sullivan; *Executive*, Mrs. Muir, Misses V. Jennings, E. Quinn; *Reps.* to: *R.N.A.O.*, Mrs. J. Warren; *Press & The Canadian Nurse*, Miss M. Haley.

A.A., Kingston General Hospital

Hon. Pres., Miss L. D. Acton; Pres., Miss Emma L. Sharpe, K.G.H.; First Vice-Pres., Miss Elsie Duncan, K.G.H.; Sec. Vice-Pres., Mrs. Gwen Hunt, 313 Collingwood St.; Sec., Miss G. B. McCulloch, K.G.H.; Treas., Miss Olevia M. Wilson, K.G.H.; Assist. Treas., Miss Emma MacLean, 313 Frontenac St.

A.A., St. Mary's Hospital, Kitchener

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A A., Ross Memorial Hospital, Lindsay

Hon. Pres., Miss E. S. Reid; Pres., Mrs. I. Radman; First Vice-Pres., Miss G. Lehigh; Sec. Vice-Pres., Mrs. U. Cresswell; Sec., Miss A. Webber; Treas., Mrs. D. Elliott; *Committees: Red Cross Supply*, Miss L. Gillespie; *Program*, Mrs. Williamson, Miss A. Flett; *Refreshment*, Misses Pogue, C. Fallis; *Notification of Meetings*, Miss B. Marsh; *Rep.* to: *Press*, Miss Strath.

A.A., Ontario Hospital, London

Hon. Pres., Miss F. Thomas; Pres., Mrs. E. Grosvenor; Vice-Pres., Mmes P. Soutar, M. Duncan; Sec., Mrs. E. Bruner, 207 Mill St.; Treas., Miss N. Williams; Assist. Sec.-Treas., Miss L. Steele; *Committee Conveners: Social*, Mrs. P. Robb; *Social Service*, Mrs. M. Millen; *Flower Fund*, Mrs. E. Grosvenor.

A.A., St. Joseph's Hospital, London

Hon. Pres., Rev. Sr. St. Elizabeth; Hon. Vice-Pres., Rev. Sr. Ruth; Pres., Miss C. Murray; Vice-Pres., Mrs. P. Chapman, Miss M. Foxworthy; Rec. Sec., Miss E. Eckert; Corr. Sec., Miss M. Mahoney, 194 Cromwell St.; Treas., Miss F. Albert; *Conveners: Social*, Misses E. Haggerty, M. McGrath; *Finance*, Miss F. Albert, Mrs. M. McCormick; *Reps.* to: *Press*, Miss M. Walker; *Registry*, Misses M. Baker, E. Beger; *The Canadian Nurse*, Miss S. Gignac.

A.A., Victoria Hospital, London

Hon. Pres., Miss H. Stuart; Hon. Vice-Pres., Mrs. A. E. Silverwood; Pres., Miss M. Stevenson; Vice-Pres., Mmes V. Fry, R. Hagerman; Rec. Sec., Mrs. S. McGugan; Corr. Sec., Miss M. Sloan, 200 Central Ave.; Treas., Miss V. Watson, 384 Waterloo St.

A.A., Niagara Falls General Hospital

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A.A., Soldiers' Memorial Hospital, Orillia

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A.A., Oshawa General Hospital

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A.A., Lady Stanley Institute (Incorporated 1918) Ottawa

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A.A., Ottawa Civic Hospital

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A.A., Ottawa General Hospital

Hon. Pres., Sr. Marie Alban; Pres., Sr. Madeleine de Jesus; Vice-Pres., Mmes N. Chassé, H. Racine; Sec., Miss J. Stock, 390 Chapel St.; Treas., Miss M. R. Nadon; *Councillors*, Misses V. Belier, G. Boland, H. Chamberlin, V. Foran, J. Robert, K. Ryan; *Reps.* to: *Registry*, Misses M. Landreville, M. Butler, A. Sanders; *Sick Benefit*, Miss J. Frappier; *D.C.C.A.*, Miss M. O'Hare; *Red Cross*, Mrs. A. Powers; *The Canadian Nurse*, Miss J. Stock.

A.A., St. Luke's Hospital, Ottawa

Hon. Pres., Miss E. Maxwell, O.B.E.; Pres., Mrs. A. Stewart; Vice-Pres., Mrs. R. Brown; Sec., Miss E. Honeywell, 50-2nd Ave.; Treas., Mrs. E. Swerdfager, 49 Glen Ave.; *Committees: Flower*, Mmes E. Pritchard, J. Harper; *Insurance*, Miss I. Johnston; *Nominating*, Miss N. Lewis, Mrs. J. McFarlane; *Reps.* to: *Community Nursing Registry*, Misses D. Brown, F. Meredith; *Local Council of Women*, Mrs. W. Creighton, Miss N. Lewis; *Press*, Mrs. R. Gamble; *The Canadian Nurse*, Miss I. Johnston.

A.A., Owen Sound General and Marine Hospital

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A.A., Peterborough Civic Hospital

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A.A., Sarnia General Hospital

Hon. Pres., Miss Rahno Beamish; Pres., Miss Olive Banting; Sec., Miss Elaine Dobson-Smith, S.G.H.; Treas., Miss Elizabeth F. Russell, S.G.H.; *Rep.* to: *The Canadian Nurse*, Mrs. Mary Elrick, 141 Penrose St.

A.A., Stratford General Hospital

Pres., Miss E. Wilson; Vice-Pres., Miss E. Stewart; Sec., Mrs. J. Robertson, 64 Grant St.; Treas., Miss M. McMaster; *Committee Conveners: Social*, Miss R. Cleland; *Flower*, Miss B. Schellenberger; *Program*, Miss G. Dahms.

A.A., Mack Training School, St. Catharines

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A.A., St. Thomas Memorial Hospital

Hon. Pres., Miss I. Stewart; Hon. Vice-Pres., Miss L. Johnson; Pres., Miss B. Pow; Vice-Pres., Mrs. E. Arleine; Sec., Miss E. Hudson, 20 Meda St.; Treas., Mrs. B. Evans, Memorial Hospital.

A.A., The Grant Macdonald Training School for Nurses, Toronto

Hon. Pres., Miss P. L. Morrison; Pres., Mrs. B. Darwent; Rec. Sec., Miss I. Lucas; Corr. Sec., Mrs. P. Jacques, 23 Fuller Ave., Toronto 3; Treas., Miss M. McCullough; *Social Convener*, Mrs. Smith.

A.A., Hospital for Sick Children, Toronto

Pres., Mrs. H. Clifford; Vice-Pres., Misses P. Norton, F. Watson; Rec. Sec., Miss Mary Heffelfinger; Corr. Sec., Miss I. Emmerson, H.S.C.; Treas., Miss D. Muckle; Assist. Treas., Miss H. Rolstin.

A.A., Riverdale Hospital, Toronto

Pres., Miss A. Armstrong; First Vice-Pres., Mrs. J. Bradshaw; Sec. Vice-Pres., Mrs. G. Bourne; Sec., Miss Olga Gerker, Riverdale Hospital; Treas., Mrs. T. Fairbairn, 98 du Vernet Ave.; *Conveners: Program*, Miss K. Mathieson; *Visiting*, Mmes C. Spreeman, H. Dunbar; *R.N.A.O.*, Miss M. Ferry; *Rep.* to: *The Canadian Nurse*, Miss A. Armstrong.

A.A., St. John's Hospital, Toronto

Pres., Mrs. M. Owen, 53 Turner Rd.; Vice-Pres., Miss E. Price, 97 Avenue Rd.; Miss F. Young, 227 Milverton Blvd.; Rec. Sec., Mrs. D. Nelles, 73 Springmount Ave.; Corr. Sec., Miss M. Turnbull, 83 Balloil St.; Treas., Mrs. P. E. Thring, 14 Glencastle St.

A.A., St. Joseph's Hospital, Toronto

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A.A., St. Michael's Hospital, Toronto

Hon. Pres., Rev. Sr. Margaret; Hon. Vice-Pres., Rev. Sr. M. Kathleen; Pres., Miss M. Regan; Vice-Pres., Misses K. Meagher, L. Riley, M. McGarrell; Treas., Miss N. O'Connor; Assist. Treas., Miss E. Cunningham; Rec. Sec., Miss C. Damon; Corr. Sec., Mrs. M. Forrester, 185 Glenholme Ave.; *Councillors*, Mrs. T. Scully, Misses E. Crocker, D. Murphy, K. Boyle; *Membership Conveners: Active*, Miss L. Huck; *Associate*, Miss L. Bonin; *Reps.* to: *Nursing Education*, Miss G. Murphy; *Public Health*, Miss M. Tisdale; *Central Registry*, Misses E. Crocker, T. Harrison, N. Corrigan; *Hospital Care Plan*, Miss V. Murphy, Mrs. A. Romano; *Local Council of Women*, Mrs. G. Rossiter; *Press*, Mrs. E. Richards; *The Canadian Nurse*, Miss M. Herbert; *Ed. & Assist. Ed., "The News"*, Miss K. Boyle, Mrs. M. Neville.

A.A., School of Nursing, University of Toronto

Hon. Pres., Miss E. K. Russell; Hon. Vice-Pres., Miss F. H. M. Emory; Past Pres., Miss J. Leask; Pres., Miss Elvira Manning; First Vice-Pres., Miss H. Carpenter; Sec. Vice-Pres., Miss E. Dick; Sec.-Treas., Miss Ethel Greenwood, 16 Clarendon Ave.

A.A., Toronto General Hospital

Pres., Miss D. Percy; Vice-Pres., Misses M. Winter, M. Fry; Sec.-Treas., Mrs. F. P. Benner, Apt. 4, 80 Avenue Rd.; *Councillors*, Mmes R. E. Will, G. Fraser, H. A. McCaghey, Miss F. Robertson: *Committee Conveners: Program*, Miss S. Burnett; *Social*, Miss M. Dix; *Gift*, Miss M. Fry; *Scholarship*, Miss M. Winter; *Trust Fund*, Miss M. Markle; *Flower*, Mrs. W. S. Hodgens; *Membership*, Miss S. Sewell; *Nominating*, Mrs. G. Coombs; *Alumnae Room*, Miss L. Bailey; *Reps.* to: *Red Cross Club*, Miss M. Dulmage; *Press*, Mrs. D. A. MacLachlan; *Archivist*, Miss J. M. Kniseley; *Ed., "The Quarterly"*, Miss M. J. B. Thompson; *Treas., Plan for Hospital Care*, Miss M. Huntsman; *Pres., Private Duty Group*, Miss M. Dix.

A.A., Training School for Nurses of the Toronto East General Hospital with which is incorporated the Toronto Orthopedic Hospital

Hon. Pres., Miss E. MacLean; Pres., Miss L. Warman; Vice-Pres., Miss J. Collins; Sec., Miss M. Angus, T.E.G.H.; Treas., Miss N. Pike, T.E.G.H.; *Committee Conveners: Social*, Miss F. Kane; *Program*, Miss M. Hemnsworth; *Reps.* to: *Nurses Registry*, Misses E. Campbell, M. Jennings; *The Canadian Nurse*, Miss J. Collins.

A.A., Toronto Western Hospital

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